

Gastrointestinal System:

1. Gastro-esophageal Reflux Disease
2. Gastroenteritis
3. Erosive Gastritis
4. Gastric Carcinoma
5. Duodenal Ulcer
6. Duodenal Ulcer, Perforated
7. Upper GI Bleed
8. Acute Cholecystitis
9. Acute Pancreatitis
10. Appendicitis
11. Carcinoma Colon
12. Constipation
13. Intestinal Obstruction
14. Irritable Bowel Syndrome
15. Lower GI Bleed
16. Acute Diverticulitis
17. Sigmoid Volvulus
18. Ulcerative Colitis
19. Crohn's Disease
20. Hepatitis A

Endocrine System:

21. Diabetes Mellitus Type 2, chronic uncontrolled
22. Diabetes Mellitus Type 2, new onset
23. Diabetic Ketoacidosis with UTI
24. Hyper-Osmolar Non-Ketotic Coma
25. Hyperthyroidism
26. Hypothyroidism
27. Hypothyroidism with Iron Deficiency Anemia

Musculoskeletal System:

28. Acute Gout Attack
29. Cellulitis
30. Rheumatoid Arthritis
31. Septic Arthritis

Cardiovascular system:

32. Acute Pericarditis
33. Aortic Dissection
34. Atrial Fibrillation
35. Congestive Heart Failure

- 36. Congestive Heart Failure with Dilated Cardiomyopathy
- 37. Congestive Heart Failure with Hypertension
- 38. Congestive Heart Failure with Pulmonary Embolism
- 39. Infective Endocarditis
- 40. Myocardial Infarction
- 41. Pericardial Tamponade
- 42. Unstable Angina

Hematology:

- 43. Chemotherapy-Induced Febrile Neutropenia
- 44. DVT
- 45. G6PD Deficiency
- 46. Folic Acid Deficiency Anemia
- 47. Iron Deficiency Anemia
- 48. Sickle Cell Patient with Acute Chest Syndrome
- 49. Sickle Cell Patient with Cholelithiasis
- 50. ITP
- 51. TTP
- 52. Hemophilia
- 53. Von Willebrand's Disease with easy bruising
- 54. Von Willebrand's Disease with menorrhagia

Renal System:

- 55. Acute Cystitis
- 56. Acute Prostatitis
- 57. Acute Renal Failure
- 58. Chronic Renal Failure
- 59. Nephrotic Syndrome
- 60. Polycystic Kidney Disease in adult
- 61. Post-op ATN/Interstitial Nephritis due to medication
- 62. Renal Cell Carcinoma

Pulmonary System:

- 63. Asthma Exacerbation
- 64. Community Acquired Pneumonia
- 65. COPD Exacerbation
- 66. Lung Carcinoma
- 67. Lung Carcinoma with Obstructive Pneumonia
- 68. Maxillary Sinusitis
- 69. Pneumocystis Carinii Pneumonia
- 70. Pleural Effusion
- 71. Pulmonary Embolism
- 72. Solitary Pulmonary Nodule

73. Tuberculosis

Nervous System:

74. Alzheimer's Dementia

75. Headache

76. Meningitis

77. Sub-arachnoid Hemorrhage

78. Temporal Arteritis

79. Transient Ischemic Attack

Ob/Gyn:

80. Antenatal care

81. Bacterial Vaginosis

82. Candida Vaginitis

83. Trichomonas Vaginitis

84. Breast Lump

85. Dysfunctional Uterine Bleeding

86. Ectopic pregnancy

87. Menopause

88. Menopause with Osteoporosis

89. Ovarian Carcinoma, abdominal mass

90. Ovarian Torsion

91. PCOD

92. Pelvic Inflammatory Disease

93. Premature Labor

94. Toxic Shock Syndrome

95. Tubo-ovarian abscess

96. Turner's syndrome

97. UTI in pregnancy

98. Iron Deficiency Anemia in Pregnancy

99. Hyperthyroidism in Pregnancy

Pediatrics:

100. Bronchiolitis

101. Child Abuse

102. Croup

103. Cystic Fibrosis

104. Diarrhea in an Infant

105. Down's syndrome with Duodenal Atresia

106. Foreign-body Aspiration

107. Infant with Sepsis

108. Iron deficiency anemia due to cow's milk intake

109. Lead Poisoning

- 110. Meningitis in Infant
- 111. Neonatal Hyperbilirubinemia secondary to cephalhematoma reabsorption
- 112. Obesity and hypertension in adolescent boy
- 113. Otitis Media
- 114. Pneumonia in an Infant
- 115. Seizures in a child
- 116. Unknown Poisoning

Psychiatry:

- 117. Alcohol Withdrawal in an Alcoholic
- 118. Depression
- 119. Panic Attack

Trauma:

- 120. MVA with Complete Heart Block
- 121. MVA with Epidural Hematoma
- 122. MVA with Rhabdomyolysis
- 123. MVA with Splenic Rupture
- 124. MVA with Rib Fractures

General:

- 125. Angioedema/Anaphylaxis
- 126. Hypertension, New Onset
- 127. Hypertensive Emergency
- 128. Lead Poisoning
- 129. Military Recruit Physical
- 130. Narcotic Overdose
- 131. Barbiturate Overdose
- 132. TCA Overdose
- 133. Spousal Abuse

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LOGICAL APPROACH TO ANY CCS CASE :

Take a deep breath and select 'Start Case' button to begin.

You will see the case introduction. Wait! Note on the erasable board:

Setting
Age of the patient

Race of the Patient
Sex of the patient

Then click 'OK' and you will see the initial vital signs. Wait! Note on the erasable board:

Stable or unstable?

Then click 'OK' and you will see the initial history. Wait! Think and write on the erasable board:

Differential Diagnosis :

Allergies

Habits – smoking , alcohol , drugs , etc. Anything worrisome?

Then ask:

Is the patient stable or is it an emergency? A clue to this would be in the history - for emergency cases, you will see only the basic history of present illness and not the detailed history (social, past, etc). All other history will be 'unobtainable'.

If unstable, do a EMERGENT physical exam. No emergency case should get a full physical exam - it's an emergency!!

For the EMERGENT physical, choose the 'general appearance' and the relevant system. If needed, add one or two relevant systems.

After you note the results of the EMERGENT physical, stabilize patient immediately:

Airway – Intubation?

Breathing – Oxygen mask? Chest tube?

Circulation – IV fluids? Dopamine?

Drugs – Naloxone? Dextrose? Thiamine?

IV Access?

Then ask:

Does the patient's condition correlate to the setting?

Emergency or unstable patient in office needs to go to the ER immediately!! Change location if necessary.

After the patient is stable and in the right setting, proceed to 'Interval/follow-up history' and a more detailed RELEVANT physical exam.

If the patient is already a stable case in the right setting, proceed straight to the RELEVANT physical exam.

Then ask:

Is the case limited to one particular system? Like Asthma or MI?

Choose the particular system and a few related systems, based on the most likely diagnosis.

Is the case not limited to one particular system?

Choose a COMPLETE physical exam. This option is available on the top of the physical exam choices. Examples of such cases include Case for Annual Physical Exam, Child Abuse, Depression, Asymptomatic Hypertensive for Office Management, etc.

Note the significant findings on the physical exam and go back to your erasable paper and revise your Differential Diagnosis. Strike out those which are less likely and add those are more likely.

Then keeping the Differential Diagnosis in mind, consider the labs to be done.

When considering labs use this mnemonic:

I B U O P

I – Imaging → X-Rays, CT, USG, MRI, Echo, Scopy, VQ Scan, etc.

B – Blood → CBC, Basic Metabolic Panel, Lipid Profile, LFT, Smears, Cultures, etc.

U – Urine → Urinalysis, Toxicology Screen, Ketones, etc.

O – Others → Other tests which do not fall under IBU, like EKG, PEFr for Asthma, Pulse Oximetry, Biopsies, etc.

P – Pregnancy test → For any female of reproductive age presenting with abdominal or pelvic symptoms, or trauma.

When ordering labs, consider:

Is this test time-effective/time-consuming? Choose time-effective.

Is this test initial screening/confirmatory? Choose initial screening.

Is this test cheap/expensive? Choose cheap.

Is this test non-invasive/invasive? Choose non-invasive.

Then ask:

Will this test tell me anything useful? Tests like CBC, ESR, Chem 7, etc might satisfy the above criteria but will not tell you anything useful.

Are there any specific tests for this condition? Examples are Cardiac Enzymes for MI, Sweat Chloride test for Cystic Fibrosis, etc.

Are the tests in the right order? Example – Pulse Oximetry before ABG, CT before Spinal Tap, etc.

Order the labs using the Order button.

Then advance clock to the 'Next Available Result'.

Understand the results. Ask:

Is the diagnosis clear or do I need any confirmatory tests?

If diagnosis is clear, start treatment.

If confirmation is needed, order confirmatory tests and then start treatment.

Treatment :

Determine if the patient is in the right setting. If patient is in office and needs to be admitted, change location to ward. If patient is in ward and is in a serious condition, change location to ICU.

If case is admitted, order:

IV access (unless IV drugs are not indicated) – Type 'IV Access'.

Vital Signs – Type Vitals and click on 'Every 1,2, 4 or 6 hours' depending on the condition of patient.

Activity – Type 'Bed Rest' and choose 'Complete bed rest' or 'Bed rest with bathroom privileges' or type restrain and choose 'Restrain patient in bed'.

Diet – Normal, liquid, NPO, 2 gram Sodium, ADA, etc. Order ‘Diet’ and you will see the list of options, choose which is the best for this case.

Tubes – NG Tube? Foley’s catheter?

Fluids – Saline, Ringer, etc. Type ‘Fluids’ and choose which is the best for this case.

Urine output – Type ‘Urine Output’ and choose frequency. There is no option for Input/output chart.

Medications :

Stop! Check for allergies on erasable board!

Order standard drugs for this case.

Decide IV or Oral. Decide bolus or continuous. Decide frequency.

Labs :

Additional labs to confirm diagnosis?

Labs to monitor? Cardiac Monitor? Pulse Oximetry?

Consults :

Order consults if necessary. GI, Ophthalmology, Psychiatry, Genetics, Social worker, etc.

Then move clock!

Depending on severity of case, move by 30 minutes/1 hour/2 hours/3 hours/6 hours/12 hours/1 day/2 days/1 week.

Do Interval/follow-up history.

Understand the results of the labs.

Then ask:

Has the patient’s condition changed significantly?

If yes, change locations.

If the condition has improved, move the patient to the next location in the order ER --> ICU --> Ward --> Office/Home.

If the condition has worsened, move the patient to the next location in the order Home/Office --> Ward/ER or Ward/ER --> ICU.

If you are changing location from inpatient (ER/ICU/Ward) to outpatient (Office/Home):

Stop unnecessary medications and change IV medications to oral.

Discontinue IV fluids.

Remove tubes.

Remove IV access.

Schedule followup visit in 1 or 2 weeks as relevant.

Patient education or counseling or diet specific and vital to this case. Type 'patient education' and 'counsel' and see if anything is relevant to this specific case. Type 'Diet' and see if anything is relevant to this specific case.

By this time, the 5 minute screen will appear!

Then type 'counsel' and choose the relevant things. You can choose multiple things at a time. See your erasable board for any worrisome habits like alcohol or smoking!

Type 'patient education' and choose the relevant things. You can choose multiple things at a time.

Patient education / Counseling options :

Every adult person - Drive with seat belt, Exercise program, No illegal drug use.

Every person taking long-term medications - Medication compliance, Side effects of medication.

Every person who takes alcohol - Limit or stop alcohol intake.

Every person who smokes - Smoking cessation.

Every person of reproductive capacity - Safe sex techniques.

Every person with long-term conditions, life-threatening allergies, chronic illnesses - Medic Alert Bracelet.

Female requesting contraception or practicing unsafe sex - Birth control, Contraception, Safe sex techniques.

Cancer case - Cancer diagnosis.

Asthmatic - Asthma care, medication compliance.

Terminal case - Advance Directive (Family), Advance Directive (Patient) and Living will.

Every post-operative case - Deep breathing and coughing

Diabetic - Diabetic foot care, Home glucose monitoring, Diet.

Learning disorder kid - Educational remediation.

Osteoporosis - Estrogen replacement therapy.

HIV case - HIV support group, safe sex techniques.

Hypothyroidism or endocrine case - Hormone replacement therapy.

Lactose intolerance - Limit cow's milk intake, Diet.

GI bleeding, peptic ulcer case - No aspirin, Sit upright after meals.

Old age, epileptic, vision defects, narcolepsy - No driving.

Anxiety case - Relaxation techniques, Rebreathing into a paper bag.

Violent psychotic case - Restraining order.

Spousal Abuse - Safety plan.

IV drug use - No illegal drug use, SBE prophylaxis, Safe sex techniques, Stop alcohol, Smoking cessation.

Pelvic surgery - No intercourse.

STD - Safe sex techniques, Sexual partner needs treatment.

Depression - Suicide contract.

Routine screening : Schedule appropriate screening tests as per age. Type the relevant test and schedule.

Immunizations : For Pediatrics and Geriatrics as relevant. Type 'Vaccine', choose and schedule.

At the end of the 5 minutes:

Type the Final Diagnosis.

You are done!!!

93. If you give ethambutol, order an ophthalmology consult (to follow possible optic neuritis)
94. If you perform a thoracentesis (lung aspirate), send the EFFUSION as well as a peripheral blood sample for: LDH and protein (to help differentiate a transudate versus an exudates) and pH of the effusion
95. Give sickle cell disease children prophylactic penicillin continuously until they turn 5 years old
96. Any patient with a recent anaphylactic reaction (for any reason), should get “skin test” for allergens (to help prevent future disasters) and consult an allergist
97. Do not give cephalosporins to any patient with anaphylactic penicillin allergies (there is a 5% cross-reactivity)
98. Order Holter monitor on patients who have had symptomatic palpitations.
99. Any patient with a first-time panic attack gets a “urine toxicology” screen, a TSH, and “finger stick glucose”
100. All renal failure patients get: “nephrology consult”, “calcium acetate” (to decrease the phosphorus levels), “calcium” supplement, and erythropoietin

4. Location: Emergency Room

Vitals: BP: 90/60 mm Hg; HR: 124/min; RR: 24/min; Temp: 98.4F

C.C: Sudden onset abdominal pain

HPI:

A 55 years old white obese female is brought to the ER with abrupt onset of epigastric pain. The pain started 5 hours ago, is steady, boring and severe in nature and radiates to the back. It is made worse by lying supine and is better by sitting and leaning forwards. The patient also has nausea and vomiting. She denies any fevers or bowel or bladder problems. She has a past history of episodic right upper quadrant pain and fatty food indigestion, for which she never sought any medical advice. She has no allergies and is not taking any medications. The patient does not smoke and denies any alcohol use. Family history is non-contributory. Rest of the review of systems is unremarkable.

How would you approach this patient?

The initial approach should be to take some general resuscitative measures, a delay in which might be life threatening. Simultaneously, think of a differential diagnosis and order the relevant tests to rule in and rule out the disease process and its etiology. Remember you always need a thorough physical examination before establishing a diagnosis.

Order No. 1:

IV access, stat

Start IV fluids: Normal Saline, bolus

Make NPO

Continuous BP monitoring

Pulse Oximetry, stat

EKG, 12 lead, stat

Results for Order No. 1:

Oxygen Saturation is 95% on room air

EKG shows sinus tachycardia without evidence of ischemia or infarction

Order physical exam:

General appearance

HEENT/Neck

Examination of CVS

Examination of lungs

Examination of Abdomen

Examination of Rectum

FOBT

Extremities

Skin

CNS

Results of Physical Examination:

General appearance: Obese female, ill looking, diaphoretic, restless. HEENT

- Normal; No JVD. Lungs are clear to auscultation and percussion

bilaterally; Cardiovascular - S1 S2 normal, no murmurs, rub or gallop.

Abdomen is soft, tenderness is present in the epigastric area but there is

no rigidity, rebound or guarding; bowel sounds are hypoactive, no

organomegaly or free fluid. Rectal - Normal sphincter tone, no hemorrhoids

or fissures, stool is heme negative. Extremities - no edema, clubbing or

cyanosis, no calf tenderness, peripheral pulses feeble.

Meanwhile the nurse tells you that the pain is worse

Order No. 2:

Continue NPO

IV NS, continuous

Continuous BP monitoring

IV Fentanyl or Meperidine, continuous

Serum amylase, stat

Serum lipase, stat

LFTs, stat

Erect abdominal X-ray, portable

CBC with differential, stat
BMP, stat
Calcium, stat
Call me when the lab results available

Results for Order No. 2:

BP - 94/70 mm Hg
Amylase - 500 IU/L; Lipase -160 IU/L
Hgb -13 g/dl, WBC - 14,000/ uL, Platelet - 250,000/mm³, leftward shift in differential count
BUN - 30, Creatinine-1.1, Sodium -131 meq/L, Potassium - 3.6 meq/L, Chloride -101 meq/L, Bicarbonate - 26 meq/L, Calcium -10.1 mg %
LFT- Total bilirubin - 6.0 mg %, Direct bilirubin - 4.5 mg %, ALT - 35 IU/L, AST - 40 IU/L, Alkaline phosphatase - 190 IU/L
X-ray abdomen - No air under the diaphragm, no dilated bowel loops

Discussion:

Differential Diagnosis: This is a patient with acute epigastric pain. Your differential diagnosis should include acute gastritis, perforated duodenal ulcer, acute pancreatitis and acute cholecystitis. Important point here is the description of pain that radiates to the back, is made worse by lying supine and is better by sitting and leaning forwards. This is typical of acute pancreatitis and may also be seen with a perforated duodenal ulcer.

Confirming the diagnosis: The diagnosis of acute pancreatitis is confirmed by elevated amylase and lipase with the latter being more specific. These enzymes rise to three times their baseline values within 24 hours in 90 % cases. Besides, you need to order CBC, differential count, BMP, calcium, LFT to look for etiology and assess the severity of the disease that will guide you in the management of the patient. The severity of acute pancreatitis is assessed using the "Ranson's Criteria" which are not discussed here. A plain X-ray of the abdomen would help in ruling out air under the diaphragm and perforated duodenal ulcer that is high on the list of differential diagnosis.

An ultrasound imaging the liver, gall bladder and biliary tract is a useful initial investigation in patients with suspicion of gallstone pancreatitis and an abnormal LFT. However, ultrasound is a very poor modality for imaging the pancreas. On the other hand, the CT scan of the abdomen can miss gallstones and duct stones but has the advantage of visualizing the pancreas very nicely. It may be ordered when there is a doubt in the diagnosis or when you suspect complications such as necrotizing pancreatitis, pancreatic abscess or pancreatic pseudocyst (discussed in brief later on). Remember, that ultrasound and CT scan of the abdomen are not routinely indicated for establishing the diagnosis of acute

pancreatitis but may be useful when indicated; although many may argue for ordering both these tests in most cases of pancreatitis.

Discussion - The above patient results suggest that the patient has acute pancreatitis with hypovolemia and prerenal azotemia.

Likely Etiology: The two most important causes are gallstones and alcohol. The past history of right upper quadrant pain and the LFT results suggest possibility of gallstones pancreatitis in this obese female. Besides, other causes to remember include hypertriglyceridemia (triglycerides >1000 mg %), viral infections (e.g. mumps), drugs (e.g. valproic acid, estrogen, thiazide diuretics, azathioprine, didanosine) and following ERCP. Establishing the etiology is important because unlike other causes where management is conservative, the latest recommendation for gallstone pancreatitis is early ERCP, biliary sphincterotomy and stone extraction. Many a times etiology is not established and is believed to be secondary to "occult biliary microlithiasis."

Order No. 3:

Continue NPO

Continue IV fluids

Continuous BP monitoring

Ultrasound of liver, gall bladder and biliary tract, stat

Results for order No. 3:

BP - 100/70

Ultrasound - multiple gallstones and dilated common bile duct

Meanwhile the patient continues to have pain but it is better than before

Order No. 4:

Continue NPO

Continue IV fluids

Continuous BP monitoring

PT/aPTT, stat (preoperative preparation)

Gastroenterology consult for ERCP: Reason: Gallstone pancreatitis; requires possible intervention with ERCP. Please evaluate and treat.

If the case still continues, order:

Examine the patient 6 hours later

Order, repeat CBC with diff, BMP, Calcium next day.

Management:

In most patients, acute pancreatitis is a mild disease associated with only edema of the pancreatic tissue subsides spontaneously within five to seven days. These patients are managed conservatively.

1. They are kept NPO and put on IV fluids. In severe cases patients may be severely hypovolemic with prerenal azotemia, requiring massive amount of IV fluids for resuscitation. Correction of electrolytes especially hypocalcemia is important.
2. Pain control is achieved using narcotics like morphine, meperidine and fentanyl. Contrary to the previous belief, there is no data to suggest that morphine increases the sphincter of Oddi pressure and may aggravate acute pancreatitis or cholecystitis.
3. Nasogastric suction is reserved for patients with protracted nausea and vomiting or ileus and is not required routinely.
4. If the acute pancreatitis is secondary to gallstones (especially with total bilirubin >5 mg % or evidence of acute cholangitis), urgent ERCP and biliary sphincterotomy within 72 hours of presentation can improve outcome by reducing biliary sepsis. If this patient had no gallstones or the LFT was normal then it would be appropriate to manage just conservatively.
5. Acid suppression is necessary only in severely ill patient in ICU settings where the risk of stress ulcer gastrointestinal bleeding is high. Once the pain subsides, the patient can be started on clear liquids and diet advanced as tolerated.

Complications:

a) Necrotizing Pancreatitis is a more severe form of pancreatitis that usually develops in the second week, requiring CT scan of the abdomen for diagnosis. It is associated with increased mortality and morbidity secondary to multisystem organ involvement including pulmonary (ARDS) and renal (ATN). The necrotic tissue is usually sterile but may get infected. A CT guided aspiration may be needed to confirm infection if patient has persistent fever, leukocytosis, and multisystem organ failure. In addition to the routine measures discussed above these patients require enteral feedings or TPN and antibiotics if infection is present. The antibiotic of choice is Primaxin (imipenem). Further a percutaneous drainage procedure or major surgical debridement may be needed in very sick patients with infected necrotic tissue.

b) Pseudocyst is suspected in presence of severe pain or persistently elevated amylase levels. These are diagnosed with CT scan of the abdomen. Asymptomatic, nonenlarging pseudocysts of less than 6 cm can be followed clinically with serial imaging studies.

Final Diagnosis:

Acute Pancreatitis, secondary to gallstones

65. Location: Office visit

Vitals: BP: 120/80 mm Hg; HR: 84/min; RR: 14/min; Temp: 98.8F

C.C: "I am not feeling well, can't eat anything and my urine has become

dark yellow"

HPI: A 34 years old white male photographer comes to the office complaining of ill health for last 1 week. His symptoms began with low-grade fever, generalized body aches and fatigue. He has been nauseated; appetite is poor, with occasional loose stools and vomiting. He has not had any fever for last 2 days but his urine has become dark yellow in color and the stools seem to be very light colored. He also complained of right upper quadrant dull ache. He denied any hematemesis, melena, weight loss or dysuria. There is no history of jaundice or blood transfusion in the past. He has no allergies and is not taking any medications. The patient was a heavy smoker but has developed distaste for cigarettes since his illness started. He denied any alcohol use. He had been to Mexico on an assignment 3 weeks ago. He is married, lives with his wife and daughter. He is heterosexual, with only one sexual partner. Family history is non-contributory. Rest of the review of systems is unremarkable.

How would you approach this patient?

A patient with non-specific constitutional symptoms and dark yellow colored urine suggests that this could be a patient with jaundice. His vital signs and history suggest that he can be managed as an outpatient and does not need admission. Before ordering any tests, order a complete physical examination to confirm your suspicion. This will also help you in formulating a differential diagnosis and ordering the relevant tests.

Order physical exam:

Complete physical examination

Results of Physical Examination:

General appearance: Well built male, ill looking, not in distress. HEENT: Icteric sclera present; No JVD. Lungs are clear to auscultation and percussion bilaterally; cardiovascular: S1 S2 normal, no murmurs, rub or gallop. Abdomen is soft; tenderness is present in the right upper quadrant, but there is no rigidity, rebound or guarding; normal bowel sounds; liver is enlarged about 2 cm below the right costal margin, tender to palpation, firm in consistency with a smooth edge and surface; no splenomegaly or free fluid. Rectal: Normal sphincter tone, no hemorrhoids or fissures, stool is heme negative. Extremities: no edema, clubbing or cyanosis, no calf tenderness; peripheral pulses are full. Skin: no palmar erythema, no spider angioma. CNS: normal, no asterixis. Rest of the examination is within normal limits.

Order No. 1:

LFTs, stat

CBC with differential, stat

Peripheral smear, stat

Reticulocyte count, stat

BMP, stat

PT, stat

Call me when the lab results available

Results for Order No. 1:

LFT: Total bilirubin - 6.0 mg %, Direct bilirubin - 4.0 mg %, ALT - 980 IU/L, AST - 700 IU/L, Alkaline phosphatase - 190 IU/L, Protein- 7.4 g/dl, albumin-3.8 g/dl.

PT= 13.2 sec,

CBC: Hgb- 15 g/dl, WBC - 9,000/ uL, Platelet - 250,000/mm³, normal differential count

Peripheral smear: normal; Reticulocyte count: normal

BMP: BUN - 18, Creatinine-1.1, Sodium -138 meq/L, Potassium - 3.8 meq/L, Chloride -105 meq/L, Bicarbonate - 26 meq/L,

Discussion:

Differential Diagnosis: The etiology of jaundice can be divided into three broad categories - hemolytic, hepatocellular and obstructive. The hemolytic jaundice is characterized by a triad of anemia, mild jaundice and splenomegaly but the hyperbilirubinemia is unconjugated (predominantly indirect bilirubin). The peripheral smear may show some abnormal cells suggestive of hemolysis and reticulocyte count is elevated. This patient has jaundice with conjugated hyperbilirubinemia (predominantly direct acting bilirubin) narrowing the possibility to hepatocellular and obstructive pathology. The significant elevation of aminotransferases and only mild elevation of alkaline phosphatase in this patient makes the possibility of obstructive jaundice (e.g. stones, strictures or cancer) less likely. This implies that this patient most likely has a hepatocellular cause. The causes of acute hepatocellular jaundice would include infections (mainly viral), drugs (e.g. acetaminophen), toxins (e.g. mushroom), alcohol and ischemic. Remember that in acute alcoholic hepatitis the AST/ALT ratio is >2:1, but transaminases are never >300.

This patient's recent visit to Mexico (developing nation), incubation period of 2 weeks after return from Mexico, onset with fever during the anicteric phase, fever resolving with onset of jaundice and aversion to cigarettes suggest viral hepatitis A. Hepatitis A is the most common form of acute viral hepatitis in the USA and worldwide. He does not have risk factors for hepatitis B or C. Remember, that although feco-oral route is the most common mode of hepatitis A infection, homosexual men and IV drug users are also at an increased risk. Its incubation period varies from 15 to 50 days.

Confirming the diagnosis: The diagnosis of acute viral hepatitis can be confirmed by ordering anti-HAV antibodies. These are of two types- IgM and IgG. Both the antibodies may be present in the serum soon after the onset

of illness. But the presence of the IgM anti-HAV antibody confirms the diagnosis of hepatitis A. The IgM antibody peaks during first week and disappears within 3-6 months. The presence of IgG anti HAV antibody in the absence of IgM indicates a previous exposure, non-infectivity and immunity against recurring hepatitis A infection.

Order No. 2:

Anti-HAV antibodies (IgM and IgG)

*Could also order a Hepatitis B (HBsAg, IgM anti-HBc ab), Hepatitis C (Hep C antibody) screening panel if risk factors were present.

Bed rest with bathroom privileges,

Antiemetics PRN (Phenergan, oral, continuous because there is no PRN (as needed) option in software)

Diet, advance

No alcohol,

No acetaminophen or hepatotoxic drugs (these are 2 not available in software)

May send the patient home, repeat appointment once the results available

Results for order No. 2:

Patient comes for return visit the next day

IgM anti HAV antibody positive

IgG anti HAV antibody positive

Order:

Interim history and brief focused physical exam

Results:

Patient feels weak, continues to have poor appetite; vitals stable

Patient questions about prophylaxis for his wife and daughter (May not happen in real exam)

Order No. 3:

May send the patient home again and schedule appointment for 3 days

LFT in 3 days

PT in 3 days

Rest at home, activity as tolerated

Antiemetics PRN

Diet, advance

No alcohol, acetaminophen or hepatotoxic drugs

Hepatitis A Immune globulin and Hepatitis A Vaccine for wife and daughter (May not happen in real exam)

Results for order No. 3:

Patient comes for a return visit

LFT- Total bilirubin - 8.0 mg %, Direct bilirubin -5.0 mg %, ALT - 1500

IU/L, AST - 1300 IU/L, Alkaline phosphatase - 210 IU/L

PT- 14.0 sec, INR=1.36

Patient still feels weak, continues to have poor appetite but vitals stable

Order No. 4:

May send the patient home

LFT in 3 days

PT in 3 days

Rest at home, activity as tolerated

Antiemetics PRN

Diet as tolerated

No alcohol, acetaminophen or hepatotoxic drugs

Repeat appointment with lab results

Results for order No. 4:

Patient comes for a return visit

LFT- Total bilirubin - 5.0 mg %, Direct bilirubin -3.0 mg %, ALT - 800

IU/L, AST - 700 IU/L, Alkaline phosphatase -190 IU/L

PT- 14.0 sec, INR=1.36

Patient feels better, nausea is less and appetite improved; vitals stable

If the case still continues, order:

Examine the patient 3 days later

Order, repeat LFT and PT in 3 days

Discussion:

Hepatitis A causes a self-limiting acute hepatitis. There are no chronic or carrier forms of hepatitis A.

Given the generally benign nature of hepatitis A, most patients can be treated at home with symptomatic and supportive therapies. No specific antiviral treatment is available. Intake of alcohol, acetaminophen and other potentially hepatotoxic substances should be avoided. Remember that conjugated hyperbilirubinemia is seen in viral hepatitis and do not be fooled by light colored stools. These are acholic stools because of cholestatic phase seen in infectious hepatitis causing a picture similar to obstructive jaundice. Do not be scared by high and rising levels of aminotransferases. The aminotransferases may be as high as 5000 IU/L and may show a rising trend for couple of weeks before starting to resolve. Recovery occurs in 3-16 weeks, although LFT may be impaired till one year. Encephalopathy and coagulopathy point towards hepatic failure and the need for admission.

Does this patient need vaccination?

No, since Hepatitis A infection leads to life-long immunity.

Final Diagnosis:
Acute Hepatitis A

66. Location: Emergency Room

Vitals: BP: 100/60 mm Hg (supine), 80/50 mm Hg (sitting); HR: 124/min; RR: 24/min; Temp: 98.4F

C.C: Black colored stools

HPI: A 55 years old white male is brought to the ER with a history of black colored, sticky, foul smelling stools for 48 hours. He decided to seek medical help after he vomited out bright red blood about an hour ago and felt weak and light headed. He has had six episodes of black stools in the last 24 hours. The patient has had history of epigastric pain for the last 1 month that occurs mostly on an empty stomach and is relieved with food and antacids. He denies history of fissures, hemorrhoids, jaundice or weight loss. He also has chronic low backache for six months. He has no allergies and has been taking over the counter ibuprofen on regular bases. The patient has been smoking one pack of cigarettes per day for the last 30 years. He also drinks beer regularly on weekends and parties. Family history is non-contributory. Rest of the review of systems is unremarkable.

How would you approach this patient?

This is a patient with melena and hematemesis, who is hemodynamically unstable as is obvious from the hypotension, orthostasis and tachycardia. The initial approach should be to take the general resuscitative measures, a delay in which might be life threatening. Simultaneously, think of a differential diagnosis and order the relevant tests to rule in and rule out the disease process and its etiology. Remember you always need a thorough focused physical examination before establishing a diagnosis.

Order No. 1:

IV access, stat- 2 large (18 G) IV bore needles

Start IV fluids: Normal Saline, bolus

Make NPO

Continuous BP, HR monitoring

Pulse Oximetry, stat

Results for Order No. 1:

BP- 100/70 mm Hg; HR- 116/min

Oxygen Saturation is 95% on room air

Order focused physical exam:

General appearance

HEENT/Neck

Examination of CVS

Examination of lungs

Examination of Abdomen
Examination of Rectum
FOBT
Extremities
Skin

Results of Physical Examination:

General appearance: Well built, pale looking, anxious male. HEENT: Pale conjunctiva, anicteric sclera, dry mucous membranes; no JVD. Lungs are clear to auscultation and percussion bilaterally; Cardiovascular: Tachycardia, S1 S2 normal, no murmurs, rub or gallop. Abdomen is soft, mild tenderness in the epigastric area but there is no rigidity, rebound or guarding; bowel sounds are normal, no organomegaly or free fluid. Rectal: Normal sphincter tone, no hemorrhoids or fissures, stool is black colored and heme positive. Extremities: no edema, clubbing or cyanosis, no calf tenderness, peripheral pulses feeble. Skin is normal.

Order No.2
CBC with differential, stat
BMP, stat
LFTs, stat
PT/aPTT, stat
EKG, 12 lead, stat
IV Pantoprazole (Protonix), continuous
Discontinue his ibuprofen

Results for Order No. 2:

CBC: Hgb -7.0 g/dl, Hct- 21% WBC - 11,000/ uL, Platelet - 250,000/mm³, normal differential count
BMP: BUN - 32, Creatinine-1.1, Sodium -138 meq/L, Potassium - 3.8 meq/L, Chloride -103 meq/L, Bicarbonate - 26 meq/L, Calcium -10.1 mg %
LFT: Total bilirubin - 1.0 mg %, Direct bilirubin - 0.3 mg %, ALT - 30 IU/L, AST - 28 IU/L, Alkaline phosphatase - 100 IU/L
PT=18 sec, INR=1.63
aPTT=38 sec; control=35 sec
EKG shows sinus tachycardia without evidence of ischemia or infarction

Order No. 3:
Continue NPO
Stop IV NS
Start packed RBC transfusion - 3 Units
4 Units fresh frozen plasma (FFP)
Hb and Hematocrit every 6 hours
PT after FFP transfusion
Continue Protonix infusion
Continuous BP monitoring

Admit in ICU

Call me when the lab results available

Results for Order No. 3:

BP - 110/70 mm; HR- 100/min

After 3 Units of PRBC and 4 Units FFP

Hgb-10 g/dl; Hct-30%

PT=14.5 sec, INR=1.45

Patient feels better

Order No. 4:

Gastroenterology Consult for EGD

Continue NPO

Restart IV NS, continuous

H and H every 6 hours

Continue Protonix infusion

Continuous BP monitoring

Call me when the lab results available

Results for Order No. 4:

EGD- clean based ulcer in the first part of duodenum. Biopsy taken

Hgb-10.2 g/dl; Hct- 30.6 %

BP- 120/80; HR- 90/min

Order No. 5

Discontinue NPO

Stop IV NS

Starts clears and advance to regular diet as tolerated

H and H every 6 hours

Stop IV Protonix

Start Protonix, oral

Continue BP monitoring

Results of order No. 5:

Patient is tolerating regular diet

Hgb-10.0 g/dl; Hct- 30.0 %

BP- 128/80; HR- 74/min

Biopsy is positive for inflammation, ulceration, no malignant cells

Tissue is negative for Helicobacter pylori

Order No.6

Discharge the patient home after overnight watch

Send home on protonix for 4-8 weeks, make follow-up appointment in 2 weeks

Patient education

Recheck Hb and Hematocrit with return visit

Start Ferrous sulfate, continuous (Optional)
Avoid NSAIDs (Type - No aspirin)
Stop smoking
Stop alcohol

Discussion:

Differential Diagnosis: Hematemesis and melena suggest upper gastrointestinal (UGI) hemorrhage. UGI bleed by definition is bleeding proximal to the ligament of Treitz. Remember that while presence of hematemesis always suggests UGI bleed, not all patients with UGI bleed have hematemesis. Melena most often is seen with an UGI bleed but may also be seen sometimes with proximal lower GI bleeding. It is in this situation (i.e. melena with no hematemesis) that a nasogastric tube placement and aspiration will be useful. Presence of fresh blood or coffee ground aspirate will suggest fresh or old UGI bleed respectively. The nasogastric tube can then also be used for lavage with tap water to clear the stomach before esophagogastroduodenoscopy (EGD). A negative finding on nasogastric lavage does not rule out an upper GI bleed as bleeding might have stopped or may have been distal to the gastric pylorus. However, a bilious lavage rules out with certainty an upper GI bleed. A nasogastric tube was not put in this patient, as there was a definite history of hematemesis.

Hematochezia (bright red blood per rectum) is seen more commonly with a lower GI bleed but may sometimes be seen with an UGI bleed if it is severe and rapid. The elevated BUN with normal creatinine is another pointer towards UGI bleed.

The most common causes are peptic ulcer disease (stomach or duodenum), gastric erosions and esophageal varices. The less common ones include Mallory Weiss tear (suspect in an alcoholic, with severe retching and vomiting), neoplasm, esophagitis, and arterio-venous malformations. This patient with his history of pain that is relieved with food and use of ibuprofen is certainly a candidate for duodenal ulcer. Other risk factors include smoking and alcohol use.

Management: Hemodynamic stabilization is more important before an EGD.

1. All patients with UGI bleeding should have two large bore (18 G or larger) peripheral IV lines.
2. Patient should be resuscitated with blood transfusions to keep a hematocrit greater than 30%. If coagulopathy is present, transfusion with FFP and administration of Vitamin K is needed to keep the INR below 1.5. Platelet transfusions may be needed for platelet counts of less than 50,000/ mm³. Calcium levels should be monitored as multiple transfusions may lead to hypocalcemia requiring specific therapy.
3. Once the patient is stabilized the investigation of choice is an EGD that offers diagnostic and therapeutic options. This patient had a duodenal

ulcer, which is the most common cause of UGI bleed. The endoscopic appearance of the ulcer predicts the risk of rebleeding and mortality. Since this patient had a clean based ulcer that carries a very little risk of rebleeding, he could resume a normal diet and be discharged within 24 hrs, as his hemoglobin was stable. Flat spots or adherent clots on EGD need observation on a general floor for 2 to 3 days. Patients with visible vessels or actively bleeding ulcers can be treated with local epinephrine injections. These lesions are associated with the highest risk for rebleeding and such patients need to be monitored in the ICU after the EGD. They should be discharged only after 3 days of stabilization. If during this period of observation rebleeding occurs then a repeat urgent EGD is needed. Such patients might need surgery if recurrent bleeding continues to occur after two endoscopic treatment attempts.

4. IV proton pump inhibitors (PPI) have been shown to reduce recurrent bleeding after endoscopic management of bleeding ulcers and may be continued for 72 hrs after EGD. At the time of discharge the patient should be put on an oral PPI for 4-8 weeks. Repeat EGD on an outpatient basis should be performed in patients with gastric ulcer to ensure healing and exclude underline malignancy. However, repeat EGD is unnecessary in patients with duodenal ulcers.

5. If the biopsy is positive for H.pylori, the patient should receive triple drug therapy for eradication of the organism. NSAIDs, smoking and alcohol need to be stopped to promote healing and prevent recurrence.

6. In patients with known cirrhosis and portal hypertension the most likely source of bleeding is esophagogastric varices. Once these patients are hemodynamically stabilized, octreotide should be started. Besides EGD is performed and sclerotherapy and band ligation of the varices can be done to stop bleeding. If octreotide and EGD intervention do not stop bleeding then a balloon tamponade (for e.g. with a Sengstaken-Blakemore or Minnesota tube) should be instituted and transjugular intrahepatic portosystemic shunt (TIPS) should be attempted to decrease portal pressure. The TIPS procedure has replaced surgery because of the significantly lower mortality rate. Once the patient has stopped active bleeding he can be discharged on a nonselective beta blocker (for e.g. nadolol or propranolol).

Final Diagnosis:

Upper gastrointestinal hemorrhage, secondary to duodenal ulcer

67. Location: Emergency Room

Vitals: BP: 104/70 mm Hg (supine), 80/50 mm Hg (sitting); HR: 120/min; RR: 24/min; Temp: 98.4F

C.C: Bright red blood per rectum

HPI: A 65 years old white female is brought to the ER with a one day history of passing bright red blood with bowel movements. She has had three episodes with moderate amount of fresh blood mixed with stools, with no anal pain. Her stools are soft in consistency and there is no history of

fissures or hemorrhoids in the past. She felt weak and light headed. There was no history of nausea, vomiting or abdominal pain. She denied any hematemesis, melena, diarrhea, constipation, jaundice or weight loss. Her past medical history is significant for type II diabetes mellitus, hypertension and hyperlipidemia. She has never had a colonoscopy in the past. She has no allergies. Her medications include glyburide, simvastatin and lisinopril. The patient does not smoke or consume alcohol. Her mother died of colon cancer at the age of 60 years. Rest of the review of systems is unremarkable.

How would you approach this patient?

This is a patient with hematochezia, who is hemodynamically unstable as is obvious from the hypotension, orthostasis and tachycardia. The initial approach should be to take the general resuscitative measures, a delay in which might be life threatening. Simultaneously, think of a differential diagnosis and order the relevant tests to rule in and rule out the disease process and its etiology. Remember you always need a thorough focused physical examination before establishing a diagnosis.

Order No. 1:

IV access, stat - 2 large (18 G) IV bore needles

Start IV fluids: Normal Saline, bolus

Make NPO

Continuous BP, HR monitoring

Pulse oximetry, stat

Results for Order No. 1:

BP - 100/70 mm Hg; HR- 124/min

Oxygen Saturation is 97% on room air

Order physical exam:

General appearance

HEENT/Neck

Examination of CVS

Examination of lungs

Examination of Abdomen

Examination of Rectum

FOBT (not required if u see a fresh bleeding)

Extremities

Skin

Results of Physical Examination:

General appearance: Pale looking, anxious female. HEENT: Pale conjunctiva, anicteric sclera, dry mucous membranes; no JVD. No palpable lymph nodes.

Lungs are clear to auscultation and percussion bilaterally. Cardiovascular:

Tachycardic, S1 S2 normal, no murmurs, rub or gallop. Abdomen is soft, non

tender, no rigidity, rebound or guarding; bowel sounds are normal, no organomegaly or free fluid. Rectal: Normal sphincter tone, no hemorrhoids or fissures, blood in rectum. Extremities: no edema, clubbing or cyanosis, no calf tenderness, peripheral pulses feeble. Rest of the exam is unremarkable.

Order No.2

CBC with differential, stat

BMP, stat

LFTs, stat

PT/aPTT, stat

EKG, 12 lead, stat

Blood Typing and Cross-match - in preparation for transfusion

Nasogastric tube placement and aspiration

Anoscopy, stat

Discontinue her glyburide, simvastatin and lisinopril

Results for Order No. 2:

BP - 100/70 mm Hg; HR- 124/min

CBC: Hgb -7.5 g/dl, Hct- 22.5 %, WBC - 12,000/ uL, Platelet - 450,000/mm³, normal differential count

BMP: BUN - 25, Creatinine -1.0, Sodium -135 meq/L, Potassium - 3.7 meq/L, Chloride -104 meq/L, Bicarbonate - 25 meq/L

LFT: Total bilirubin - 1.0 mg %, Direct bilirubin - 0.4 mg %, ALT - 31

IU/L, AST - 30 IU/L, Alkaline phosphatase - 110 IU/L

PT=17 sec, INR=1.60; aPTT=39 sec, control=35 sec

EKG shows sinus tachycardia without evidence of ischemia or infarction

Nasogastric aspirate - bilious with no blood

Anoscopy - no anal fissures; no external or internal hemorrhoids; no ulcerations in distal part of rectum

Order No. 3:

Continue NPO

Stop IV NS

Start packed RBC transfusion - 3 Units

4 Units fresh frozen plasma (FFP)

H and H every 6 hours

PT after FFP transfusion

Continuous BP monitoring

Discontinue NG tube

Complete bed rest

Apply pneumatic compressions for DVT prophylaxis

Accuchecks every 6 hours (use regular insulin as needed, based on blood sugar levels)

Admit in ICU

Examine the patient 6 hours later: order interim history and focused

physical exam (make sure you listen lungs as they may develop fluid overload with all the IV infusions).

Results for Order No. 3:

BP - 110/70 mm; HR- 100/min

After 3 Units of PRBC and 4 Units FFP

Hgb-10.5 g/dl; Hct-30%

PT=14.5 sec, INR=1.45

Patient feels better; exam looks fine

Order No. 4:

Gastroenterology consult for colonoscopy (Reason: 65 yr old with Hematochezia, no prior Colonoscopy; Please evaluate for the source of bleeding).

Continue NPO

Restart IV NS, continuous (if the lungs are clear)

H and H every 6 hours

Start bowel preparation for colonoscopy - 4 liters of polyethylene glycol (Golytely, Colyte) given over two hours

Continuous BP monitoring

Call me when the lab results available

Results for Order No. 4:

Colonoscopy - Multiple diverticuli in sigmoid and descending colon. Biopsy taken

Hgb-10.2 g/dl; Hct- 30.6 %

BP - 120/80; HR- 90/min

Order No. 5

Discontinue NPO

Stop IV NS

Start clears and advances to high fiber diet as tolerated

H and H every 6 hours

Continue BP monitoring

Results of order No. 5:

Patient is tolerating low roughage diet

Hgb-10.0 g/dl; Hct- 30.0 %

BP - 128/80; HR- 74/min

Biopsy is positive for diverticulosis, no inflammation or ulceration; no malignant cells

Order No.6

Discharge the patient home after overnight watch

High fiber diet

Restart her home medications

D/C DVT prophylaxis

Avoid nuts and fruits with seeds (No option in software)

Follow up appointment in one week with repeat Hgb and hematocrit.

Discussion:

Differential Diagnosis: LGI bleed by definition is bleeding distal to the ligament of Treitz. Most patients with bright red blood per rectum or hematochezia have a LGI bleed, but about 10% are the result of a brisk UGI bleed. Thus patients with hematochezia should have a nasogastric tube lavage to exclude an upper gastrointestinal hemorrhage. An EGD instead of the usual colonoscopy may be needed to establish the cause of hematochezia in case the nasogastric aspirate shows blood.

The most common causes are diverticulosis, angiodysplasia, polyps and colon cancer in a patient above 65 years. All these conditions are painless, except colon cancer, which sometimes may be associated with abdominal pain. This patient is at a high risk of colon cancer because of a positive family history. Another important cause to consider in this patient is ischemic colitis since she has multiple risk factors for vascular disease. However, ischemic colitis is most often associated with abdominal pain. Also remember, that diverticular bleed usually do not occur in the presence of diverticulitis. Other less common causes include inflammatory bowel disease (ulcerative colitis, crohn's disease), vasculitis (Polyarteritis nodosa, Wegner's granulomatosis), radiation colitis, and infectious colitis (Ecoli, salmonella, CMV).

Management:

1. Hemodynamic stabilization is more important before a colonoscopy. Hemodynamically unstable patients should be admitted in the intensive care unit. Presence of shock, orthostatic hypotension, a 6% drop in hematocrit or blood transfusion requirement of two or more units suggests hemodynamic instability.
2. All patients with GI bleeding should have two large bore (18 G or larger) peripheral IV lines.
3. Patient should be resuscitated with blood transfusions to keep a hematocrit greater than 30%. If coagulopathy is present, transfusion with FFP and administration of Vitamin K is needed to keep the INR below 1.5. Platelet transfusions may be needed for platelet counts of less than 50,000/ mm³.
4. Calcium levels should be monitored as multiple transfusions may lead to hypocalcemia requiring specific therapy.

5. Nasogastric tube lavage should be done. If it shows no blood or has copious bile then the investigation of choice once the patient is stabilized, is colonoscopy. Colonoscopy can localize the site of bleeding, allow tissue biopsies and therapeutic interventions like injection sclerotherapy and electrocautery. However, a good bowel preparation is needed for good visualization of the colon. If nasogastric aspirate shows blood then an EGD is recommended as the initial investigation of choice. If EGD is negative, then go ahead with colonoscopy.

What if the colonoscopy is normal but the patient continues to have hematochezia?

Order a tagged red blood cell scan (radionuclide imaging study) - Radionuclide scanning is a highly sensitive technique that can detect bleeding occurring at a rate of 0.1 to 0.5 mL/minute. However, it cannot localize the site of bleeding and requires presence of active bleeding at the time of the test. If the tagged RBC scan is positive, one must proceed with angiography.

Angiography detects blood loss as low as 0.5 mL/minute. The procedure is 100 percent specific and is performed to accurately localize the site of bleeding, especially if surgical management is needed. It also permits control of bleeding using vasopressin infusion or embolization via the catheter. However, it is an invasive procedure and needs to be performed during active bleeding.

*Remember that angiography is reserved for patients in whom colonoscopy cannot localize the site of bleeding or is not feasible.

When should I get surgery consult?

A surgical consultation is needed for continued severe bleeding with high transfusion requirements. A blind surgery performed without localizing the site of bleeding carries a higher risk of rebleeding. Hence, if feasible a tagged RBC scan and angiography should be done before proceeding for surgery.

Final Diagnosis:

Lower gastrointestinal hemorrhage, secondary to diverticulosis.

68. Location: Emergency Room

Vitals: BP: 80/50 mm Hg; HR: 40/min; RR: 24/min; Temp: 98.4F

C.C: Lightheadedness

HPI: A 55 years old male victim of a motor vehicle accident is brought to the ER by ambulance. He was a unrestrained driver of a car that hit a tree due to poor visibility on that foggy night. The patient complains of mild generalized body ache, severe chest pain and lightheadedness. He remembered his chest having struck against the steering wheel. However, there was no

history of head injury, headache or loss of consciousness. He did not complain of respiratory distress. The patient was feeling uncomfortable with the Miami-J collar put by the EMS team around his neck at the site of the accident. He has no allergies and denied being on any medication. Rest of the review of systems is unremarkable.

How would you approach this patient?

This is a victim of motor vehicle accident, who is hemodynamically unstable as is obvious from the hypotension and bradycardia. The initial approach should be to take the general resuscitative measures, a delay in which might be life threatening. Simultaneously, think of reasons for hypotension and bradycardia in an accident victim and order the relevant tests. Remember you always need a thorough physical examination to rule out serious injuries and decide which body parts to image.

Order No. 1:

IV access, stat- 2 large (18 G) IV bore needles
Start IV fluids: Normal Saline, bolus
Continuous BP, HR monitoring
Pulse oximetry, stat

Results for order No 1:

BP- 80/50 mm Hg; HR- 34/min
Oxygen Saturation is 95% on room air

Order examination:

General
Heart
Lungs

Results of the exam:

General appearance: Well-built, white male, in severe pain, holding on to his chest with his right hand. Lungs are clear to auscultation and percussion bilaterally; Cardiovascular - Bradycardia, variable intensity of S1 and S2; no murmurs, rub or gallop.

Order No 2:

EKG, 12 lead, stat
Chest-X ray, PA portable
X-ray cervical spine, stat
IV Fentanyl or Ketorolac, bolus

Results of Order No 2:

EKG shows complete heart block, ventricular escape rhythm with a rate of 40/min, QRS duration of 140 msec. No evidence of ischemia or injury except nonspecific ST/T changes.

Chest X-ray: Fracture of the left 3rd and 4th ribs. No pneumothorax or effusion. Heart and mediastinum are normal in size and configuration.
X-ray cervical spine: Normal

Order No 3:

Atropine 0.5 mg IV stat

Put patient on transcutaneous pacemaker

Consult Cardiology, stat (for transvenous pacemaker placement)

Consult Orthopedics, stat (to rule out cervical spine injury and get rid of Miami-J collar)

Make NPO

CBC with differential, stat

BMP, stat

PT/aPTT, stat

Results of Order No 3:

CBC: Hgb -13.0 g/dl, Hct - 39% WBC - 9,200/uL, Platelet - 250,000/mm³, normal differential count

BMP: BUN - 19, Creatinine-1.1, Sodium -138 meq/L, Potassium - 3.8 meq/L, Chloride -103 meq/L, and bicarbonate - 26 meq/L.

PT=13 sec, INR=1.23; APTT=33 sec; control=35 sec

Order No 4:

Check the BP and HR

Result of Order No 4:

Transcutaneous pacemaker paces at rate of 80/min, BP-90/60

Patient's lightheadedness and chest pain is better

Order examination of:

HEENT/Neck

Abdomen

Extremities

Skin

CNS

Results of Physical Examination:

HEENT: Normocephalic, atraumatic, PERLA, EOMI, pink conjunctiva, anicteric sclera, moist mucous membranes, no ear or nose bleed; Neck- Miami J collar on; Abdomen is soft, no tenderness, rigidity, rebound or guarding; bowel sounds are normal, no organomegaly or free fluid. Extremities - no edema, clubbing or cyanosis, no calf tenderness, peripheral pulses feeble.

Neurological exam-awake, alert oriented, moves all four limbs with no focal neurological deficits.

Order No. 5:

Continuous HR and BP monitoring

Continue NPO
Continue NS
CK and MB, stat
Troponin T, stat
Echocardiogram, stat

Results for Order No. 5:

CK- 500; MB-11

Troponin T- 0.500

Echocardiogram: EF=55 - 60, no wall motion abnormalities, all valves are normal, no pericardial effusion

Cardiologist takes the patient to the cardiac cath lab for a temporary transvenous pacemaker insertion.

If case continues further, may need permanent pacemaker insertion.

Discussion:

The most important cause of hypotension in a trauma victim is hemorrhage. The first step in management would be to start IV fluids and send a CBC to look for the amount of blood loss. If there is no overt bleeding one must look for an occult collection in the chest and abdomen, for which you need to do imaging studies. Normally, patients develop tachycardia in response to hypotension secondary to hypovolemia. The bradycardia accompanying the hypotension and the normal hemoglobin in this patient should make you suspicious of an etiology other than bleeding.

The EKG confirms the diagnosis of complete heart block (CHB). CHB is a third degree AV block the diagnosis of which is made by AV dissociation with a slow ventricular escape rhythm of around 40 beats/min. The atria may be in sinus rhythm or in fibrillation but the 'P' waves do not bear any relationship with the QRS complexes. However, it is also important to establish the etiology of CHB since it aids in the further management. The most important causes are fibrosis or degeneration of the conduction system and ischemic heart disease. The others include drugs (beta blockers, calcium channel blockers, digitalis, amiodarone), metabolic abnormalities (hyperkalemia), valvular heart disease, and cardiomyopathy (amyloid, sarcoid, hypertrophic cardiomyopathy).

Remember, trauma is an uncommon cause of CHB. Absence of ST-T changes suggestive of ischemia in EKG and no wall motion abnormalities excluded the possibility of acute coronary syndrome. The elevated CK, MB and Troponin T were probably secondary to myocardial contusion. The patient was not on any heart rate lowering drugs, his electrolytes were normal and Echo further ruled out any valvular abnormalities, cardiomyopathy or pericardial effusion.

The only modality of treatment for complete heart block is pacing. Atropine is only of little benefit and may sometimes transiently improve the heart rate and the blood pressure. These days the life packs are equipped with pads for transcutaneous pacing. But these should be used only as a bridge for the transvenous pacing. The transvenous pacing may be a temporary pacing to begin with. In this patient, if the CHB persists for the next couple of days, a permanent pacemaker can be placed.

Patients with second-degree atrioventricular blocks who are asymptomatic and hemodynamically stable may be managed without a pacemaker. However, a complete heart block even in the absence of symptoms warrants a pacemaker, since you are not sure when the patient may become unstable.

Another important thing is to avoid medications that would cause bradycardia and hypotension. This patient has rib fracture and a lot of chest pain. Use of morphine may worsen his hemodynamic parameters. So, ketorolac or fentanyl would be better options for pain control in these patients.

Final Diagnosis:

Motor vehicle accident with complete heart block (secondary to myocardial contusion)

69. Location: Emergency Room

Vitals: BP: 100/60 mm Hg; HR: 104/min; RR: 30/min; Temp: 100.4F

C.C: Generalized bodyache and weakness

HPI: A 80 years old white male is brought to the ER by his son. His son found him lying in the woods on a hot sunny day. It seemed that the patient had gone for a stroll last evening and fell down. He was unable to get up, shouted for help but could not get any. He had been lying on the ground for the last 24 hours till his son found him. The patient complained of severe bodyache. He felt very weak and was thirsty. He denied having lost consciousness. He did not pass urine for the past 24 hours. There was no history of head injury or seizures. He has no allergies and is not taking any medications. The patient does not smoke and denies any alcohol use. Family history is non-contributory. Rest of the review of systems is unremarkable.

How would you approach this patient?

This is an 80 years old man who had a fall and had been lying on the ground for more than 24 hours on a hot sunny day with no help. He is hemodynamically stable. The generalized bodyache is a hint towards possible muscle injury and should be a guide for ordering further diagnostic tests. Remember you always need a thorough physical examination to rule out serious injuries and decide which body parts to image.

Order No. 1:
IV access, stat
Pulse oximetry, stat

Results for order No 1:
Oxygen Saturation is 95% on room air

Order examination:
Complete

Results of the exam:
General appearance: Well-built, in dirt laden clothes, appears extremely dry and weak. HEENT-normal; Neck- no JVD; Respiratory - Clear to auscultation bilaterally; Cardiovascular- Tachycardia, S1 S2 normal, no murmur, rub or gallop; Abdomen-soft, non-distended, non-tender, normal bowel sounds, no organomegaly; Extremities- no edema, clubbing or cyanosis, no calf tenderness, peripheral pulses feeble; Neurological- awake, alert, oriented, no focal neurological deficit

Order No 2:
Start IV fluids: Normal saline, bolus
Insert Foley's catheter, stat
CBC with differential, stat
BMP, stat
EKG, 12 lead, stat
Urinalysis

Results for order No 2:
The nurse reports that the patient could give her only 5 cc of dark brown urine
CBC: Hgb -13.0 g/dl, Hct - 39% WBC - 13,200/uL, Platelet - 250,000/mm³, normal differential count
BMP: BUN - 45mg%, Creatinine-2.6 mg%, Sodium -134 meq/L, Potassium - 5.5 meq/L, Chloride - 92 meq/L, and bicarbonate - 17 meq/L. Calcium- 8.0 mg%
EKG shows sinus tachycardia
Urine dipstick- positive for blood; Urine microscopic- no RBC, no WBC, reddish-gold pigmented casts

Order No 3:
CPK, stat
Ionized calcium, stat
Serum magnesium, stat
Serum phosphorus, stat
Serum uric acid, stat
Urine myoglobin, stat
PT/INR, stat
APTT, stat

Admit in floor
Vitals Q 2 hours
Urine output, hourly
Activity as tolerated
IV NS, continuous

Results of Order No 3:
CPK- 10,500 IU/L
10 cc urine in Urobag
Ionized calcium- 0.99 mmol/L
Serum magnesium- 1.8 meq/L
Serum phosphorus-5.5 mg/dl
Serum uric acid- 8.5 mg/dl
Urine myoglobin- positive
PT- 14.2 sec, INR-1.40; APTT-35 sec

Order No 4:
Inform in 4 hours

Result of Order No 4:
BP-110/80 mmHg, HR-104/min
Urine output- 75 ml/hr
Order No. 5:
Stop 0.9% Saline
Start 0.45% Saline (with mannitol and Soda bicarbonate added to it)
Monitor urine pH every 1 hour
Titrate the mannitol - bicarbonate drip for urine pH> 6.5 and Urine output
of >300 mL/hr
Check CPK in 4 Hours
Check BMP in 4 Hours
Check Magnesium and phosphorus in 4 Hours

Result of Order No 5:
CPK- 9000 IU/L
BMP: BUN-38mg%, Creatinine-2.1 mg%, Sodium -138 meq/L, Potassium -5.0
meq/L, Chloride -101 meq/L, and bicarbonate - 21 meq/L. Calcium- 8.2 mg%
Serum Magnesium- 1.4 meq/L
Serum Phosphorus- 5.0 mg/dl
BP-130/80 mm Hg; HR-96/min
Urine pH-7.2
Urine output- 1300 cc in last 4 hours

Nurse says that the patient is feeling better

Order No. 6:
Stop mannitol-bicarbonate diuresis

Start 0.45% saline, continuous
Check BMP, every six hours
Check serum magnesium every 6 hours
Check serum phosphorus every 6 hours
Check CPK, every 12 hours

Discussion

This is a case of rhabdomyolysis. Prolonged immobilization and compression of muscles lead to ischemic muscle damage. The hot climate and dehydration contributed to the myoglobin induced acute tubular necrosis. This resulted in acute renal failure with anion gap metabolic acidosis and the electrolyte abnormalities seen with rhabdomyolysis.

Rhabdomyolysis is a syndrome resulting from skeletal muscle injury with release of myoglobin and creatine phosphokinase (CPK) into the plasma. The myoglobinuria, acid urine pH and renal hypoperfusion resulting from hypovolemia leads to precipitation of heme proteins and acute tubular necrosis.

Etiology:

1. Traumatic causes: Crush syndrome, burns, electrocution,
2. Non-traumatic causes:
Muscle hyperactivity- strenuous physical exercise, seizures, delirium tremens
Muscle compression- prolonged immobilization, coma
Muscle ischemia- acute arterial occlusion
Malignant hyperthermia, neuroleptic malignant syndrome, hypothermia
Infections- Viral including HIV, bacterial, etc.
Drugs - alcohol, heroin, cocaine, amphetamines, zidovudine, statins
Metabolic disorders- hypocalcaemia, hypokalemia, hypophosphatemia, hypothyroidism, hyperthyroidism, diabetic ketoacidosis
Metabolic myopathies- e.g. Carnitine palmitoyltransferase deficiency. These should be suspected in patients with recurrent episodes of rhabdomyolysis after exertion.
Others- carbon monoxide, snake bite

Remember that inflammatory myopathies like polymyositis and dermatomyositis very rarely give rise to rhabdomyolysis and acute renal failure.

Diagnosis:

The most common complaint is muscular pain, which is very non-specific. Moreover, a comatose patient will not complain. Dark brown urine may be the only visible sign. Suspect rhabdomyolysis in a patient with renal failure, who has blood present on urine dipstick but no RBC on microscopic examination. This is because the myoglobin in the urine causes the urine dipstick to be falsely positive for blood. Plasma creatinine concentration rises more rapidly with rhabdomyolysis (up to 2.5 mg/dL per day) than with other causes of acute renal failure. In contrast to other forms of acute

tubular necrosis, FENa is less than 1 percent.

The diagnosis of rhabdomyolysis is made by measurement of CPK. It begins to raise 2 to 12 hrs after the injury and reaches its peak value 1 to 3 days after injury. The peak may range from several hundred IU/L to over 200,000 IU/L in a full blown crush syndrome. Therefore, CPK should be measured daily for at least 3 days to follow extent of muscle damage. If the serum CPK remains elevated despite treatment, ongoing muscle injury, necrosis and/or compartment syndrome should be sought.

Myoglobin is also released from the injured muscle. It increases before CPK and decreases more rapidly owing to its clearance by kidneys and metabolism to bilirubin. Therefore, remember that a normal serum myoglobin and absence of myoglobinuria does not exclude the diagnosis of rhabdomyolysis.

Various electrolyte abnormalities result from rhabdomyolysis. These can be better understood by grouping them into two categories

1. Influx from Extracellular compartment into muscle cells- water, sodium, chloride (hypovolemic shock), calcium(hypocalcemia)
2. Efflux from injured muscle cells- potassium(hyperkalemia), purines (hyperuricemia), phosphate (hyperphosphatemia), lactic acid (metabolic acidosis), myoglobin(myoglobinuria, nephrotoxicity), thromboplastin (DIC), creatine kinase, creatinine (increased serum creatinine-to-urea ratio)

Management:

1. Fluid replacement is the mainstay of therapy. Use normal saline and initiate at 1.5 L/hr. The aim is to wash off the myoglobin from the renal tubules, establish a good urine output and prevent or limit acute tubular necrosis. While on one hand many electrolyte abnormalities can precipitate rhabdomyolysis, the syndrome itself can lead to various metabolic derangements. Hence one needs to monitor the BMP and electrolytes very closely for the initial 2 days.
2. Forced alkaline diuresis using mannitol and bicarbonate is recommended by some. Alkalinization of urine prevents precipitation of myoglobin in the tubules. However, this should be used once the BP is stable and a urine output is established using isotonic saline.

One has to be careful during such large volume fluid replacement as there is always a risk of fluid overload.

Final Diagnosis:

Rhabdomyolysis due to prolonged immobilization

70. Location: Emergency Room

Vitals: BP: 120/80 mm Hg; HR: 112/min; RR: 28/min; Temp: 101 F

C.C: Fatigue and right upper quadrant abdominal pain

HPI: A 74 years old white male presents to the ER with a 3 days history of fatigue and right upper quadrant abdominal pain. His pain is a dull in character, moderate intensity, poorly localized with no radiation to back or shoulder. It increases with deep inspiration. He denies any fever, cough or sputum production but complains of profuse sweating off and on. He has poor appetite with some nausea but no vomiting. There is no history of bowel or bladder problems. The past medical history is significant for type II diabetes mellitus. He has no allergies and is taking glipizide for his diabetes. The patient denies any tobacco or alcohol abuse. There is no history of sick contacts. He is a widower and lives alone. Family history is non-contributory. Rest of the review of systems is unremarkable.

How would you approach this patient?

This is a 74 years old patient with acute onset right upper quadrant pain and non-specific constitutional symptoms. First think of a differential diagnosis of right upper quadrant pain. The possibilities are: acute cholecystitis, cholangitis, choledocholithiasis, hepatitis, pyelonephritis, appendicitis and pneumonia. The absence of dysuria, back pain and normal urine color make the possibility of hepato-biliary and renal pathology a little less likely but not impossible. Moreover, absence of fever, cough and sputum point against the diagnosis of pneumonia. In such a situation one should perform a good physical examination to narrow down the list of differential diagnosis and order relevant tests.

Order No. 1

Pulse Oximetry, stat

Results of Order No.1

Oxygen Saturation- 89 % on room air

Order No. 2

Start oxygen by nasal canula @ 4 L/min

Order physical exam:

General appearance

HEENT/Neck

Examination of heart

Examination of lungs

Examination of abdomen

Examination of extremities

CNS

Skin

Results of Physical Examination:

General appearance: Well built male, toxic looking, tachypneic. HEENT: Anicteric sclera, No JVD.

Lungs: crackles over the right lung base, no rhonchi or rub;
Cardiovascular: Tachycardic, S1 and S2 are normal, no murmurs, rub or gallop. Abdomen is soft, non-tender, no rigidity, rebound or guarding; normal bowel sounds; no organomegaly or free fluid. Extremities: No edema, clubbing or cyanosis, no calf tenderness, peripheral pulses palpable. Skin: No rash. CNS- normal.

Order No. 3:

X-ray Chest, PA and lateral stat

EKG, 12 lead, stat

CBC with differential, stat

BMP, stat

LFT, stat

Results for Order No. 3:

X-ray Chest- Right lower lobe infiltrate suggestive of right lower lobe pneumonia, normal cardiac size, no pleural effusion

Hgb -13.5 g/dl, WBC - 16,500/ uL, Platelet - 350,000/mm³, Differential count: 90 % polymorphs, 8% lymphocytes, 20 % bands

BUN - 18, Creatinine-1.1, Sodium -138 mEq/L, Potassium - 3.8 mEq/L, Chloride -105 mEq/L, Bicarbonate - 26 mEq/L, Calcium -10.1 mg %

LFT - Completely normal

EKG - Sinus tachycardia

Order No. 4:

Admit the patient on regular floor

Blood cultures, 2 sets, stat

Sputum Gram stain, stat

Sputum cultures, stat

Start antibiotics after drawing blood cultures - Levofloxacin/gatifloxacin or Ceftriaxone + azithromycin, IV continuous

Acetaminophen, PRN for fever and pain

Check Vitals every 4 hours

Pulse Oximetry, Q 2 hours

Bed rest with bathroom privileges

Pneumatic compression for DVT prophylaxis

Diabetic diet

Plenty of oral fluids

Acu checks, QID (4 times a day)

Continue his oral glipizide

Pneumovax and Influenza vaccination if not received earlier

Review after 12 hours

Order interim history and focused physical exam

Results for Order No. 4:

Vitals: BP: 120/80 mm Hg; HR: 96/min; RR: 20/min; Temp: 99 F

Oxygen saturation- 100% on 4L/min of oxygen by nasal canula

Order No. 5:

Continue same treatment

CBC/differential after 24 hours

Call me with the results

Results for Order No. 5:

After 24 hours, the nurse reports that patient feels better.

No nausea; feels stronger and wants to eat

Vitals: BP: 120/80 mm Hg; HR: 80/min; RR: 16/min; Temp: 98 F

Oxygen saturation- 95% on room air

Blood cultures - no growth after 24 hours

Hgb -13.0 g/dl, WBC - 11,500/ uL, Platelet - 350,000/mm³, Differential count: 82 % polymorphs, 8% lymphocytes, and 10% bands

Blood sugar - stable on diet and oral hypoglycemics

If case continues- Stop IV antibiotics; plan to send patient home on oral antibiotics for 7-10 days. Make a follow-up in one week.

Discussion:

This is a case of community-acquired pneumonia (CAP) with an atypical presentation. With an abnormal chest x-ray, normal LFTs and a benign abdominal examination, no abdominal imaging studies are needed in this patient.

Certain important points to remember regarding CAP:

1.Pathogens: The most common pathogens are *Streptococcus pneumoniae* and *Hemophilus influenzae*. *Staphylococcus aureus*, gram-negative bacilli and *Moraxella catarrhalis* are less common organisms causing CAP. Atypical agents including *Legionella*, *Mycoplasma pneumoniae* and *Chlamydia pneumoniae* although not very common need to be considered when choosing a broad-spectrum antibiotic for empiric treatment of CAP.

2.Clinical Presentation: Cough, sputum production, dyspnea, fevers and sweats are the typical symptoms. However fatigue, headaches, nausea, vomiting, diarrhea and abdominal pain are some of the non-specific and atypical symptoms. Elderly patients (> 75 years) have fewer symptoms of CAP.

3.Diagnostic studies: Chest X-ray is a must for diagnosis of CAP. CBC/Diff,

basal metabolic profile, sputum cultures, blood cultures, and pulse oximetry (or ABG) are recommended before starting antibiotics. The role of routine sputum Gram stain and sputum cultures is controversial. These labs may support the diagnosis, identify the pathogen and help in making treatment decisions, regarding the need for admission. Blood cultures are positive in only 11% cases of CAP with *Streptococcus pneumoniae* accounting for 67% of the positive cultures. In case Legionnaire's disease is suspected (hyponatremia, immunocompromised, no response to Beta-lactam antibiotics) then urine should be tested for *Legionella* antigen.

4.Choice of antibiotics:

For a patient being admitted in the general medical floor/ward:

- a. Fluoroquinolone alone - levofloxacin or gatifloxacin; Do not use ciprofloxacin
- b. 2nd /3rd generation Cephalosporin (e.g. Ceftriaxone) + Macrolide (e.g. Azithromycin)

*Remember, the cephalosporins are not effective against atypicals like legionella, mycoplasma and Chlamydia; hence, it should be combined with a macrolide. Levofloxacin alone also covers atypical organisms.

For uncomplicated pneumonia in the out patient setting:

- a. Azithromycin or Doxycycline alone

Duration of antibiotics depends upon the pathogen being suspected and treated. In general it varies from 7-10 days. However, it may be 10-14 days for *Mycoplasma* and *Chlamydia* and 14-21 days for *Legionella*.

5.Decision to admit: Various guidelines and scoring systems have been developed to help in deciding whether to admit the patient or not. However, these are difficult to remember off hand. The following major points are poor prognostic factors in patients with CAP. The presence of any of these may necessitate admission.

- a. Age greater than 65 years
- b. Coexisting disease: Diabetes, renal failure, heart failure, chronic lung disease, chronic alcoholism, immunosuppression, and neoplastic disease.
- c. Clinical findings: RR >30 breaths/min, Systolic BP<90mm Hg or Diastolic BP< 60 mm Hg,
- d. Temperature>38.3 C, altered mental status, extrapulmonary site of infection (meningitis, septic arthritis).
- e. Laboratory tests: WBC <4000/mm³ or >30,000/mm³; Pao₂<60 mmHg; renal failure; multilobar involvement on chest radiograph; pleural effusion; Hct<30%.

PK's CCS cases... First wk of march

CCS-Acute Gout Attack

Step 1: Keep foot elevated, Stool guaic.

Labs: CBC, Chem 7, Uric acid,

UA with micro

Synovial fluid for light polarizing micrograph,

C&S, Gram stain, glucose, protein, cell count

X-RAY JOINT

Diet: low purine

Medication: Motrin PO or Indomethacin PO for 2 days,

then hypouricemic therapy: Probenicid... increase until UA level falls below 6.5.

Allopurinol , AFTER attack

Symptomatic: Ranitidine BID (H2 Blocker)

Meperidine or Vicodine

CCS- Splenic Rupture

Diagnosis : splenic hematoma

HPI 23 y/o male after MVA.

ABCs

PE focused

Labs: serum glucose and rapid bedside glucose determination

CBC, serum chemistries, amylase, LFTs, UA, coagulation studies, blood type and match,

ABG, blood ethanol, urine drug screens.

Bedside Ultrasound, DPL Doppler?(for unstable), CT(for stable)

Emergent Surgery Consult.

CXR, supine & erect

ABD x-ray, Abdominal sono(er) or abdominal CT

Vitals, Cardiac, and BP monitoring on bed side.

Foley catheter and Urine output check.

NS as IVF before results from Lab.

{rather than LR(ringer's lactate) in case he develops rhabdomyolysis- In MVA, NS is fluid of choice.}.

Transfer to ICU if patient is not stable.

Surgical consult for repair

Prefer NS as IVF rather than LR because in case he develops rhabdo.

(MVA) NS is fluid of choice

CCS- AMI

HPI: 45 yo pt brought to the ER c excruciating stabbing pain on chest/inner arm for 20 min. No history of previous attack, but hypertensive c BP 190/ 96 when last taken.

Pt. conscious but looks anxious.

VS: temp-97, pulse-86/min,resp. rate-33/min,

Step I : Emergent management: A, B, C, D- O2, IV access

Step II : Focused PE: Heent/Neck, Chest/Lungs, Heart/Cv, Abdomen, Extremities

Step III : Diagnostic Investigations: EKG, CXR, CK-mb, Troponin-I, CBC, Chem –7,
Continuous cardiac monitoring

Treatment:MONA

1. NTG 0.4mg sl
2. Aspirin
3. Morphine if patient is in pain
4. ACE Inhibitor (onopril)
5. Depending on time since onset (if 3 h or less), consider t-PA if not contraindicated or cardiac cath.
6. Consider NTG drip. Other antihypertensive you may consider is labatelol or nipride(more severe cases).

Step IV: Changing pt's location

1. Admit Pt. to CCU, if patient is symptomatic send to ward.
2. Repeat cardiac markers
3. D/C cardiac monitor after 24 hours if patient is stable
4. When stable, consider sub-maximal exercise test
5. All Pts. with MI should go home on B-blockers
6. Check lipid profile
7. Consult on healthy life style prior to discharge
8. Make appointment to see him in about a week

STEP V: Educate Pt's family, Console patient, stop smoking, diet, exercise.

STEP VI: Final Diagnosis.AMI

CCS-PID

HPI: 25 Year old WF c/o lower ABD pain.

PE: HEENT, urogenital/pelvic exam, (check for adnexal + cervical motion tenderness), abdominal

LABS: Pregnancy test (BetaHCG), CBC, Chem7,

Endocervical gram stain for gram-negative intracellular diplococci.

Endocervical culture-for gonorrhea

Endocervical culture or antigen test-for Chlamydia

TREATMENT: Outpatient

Hospitalization recommended in the following situations:

Uncertain diagnosis, Surgical emergencies cannot be excluded, e.g., appendicitis,

Suspected pelvic abscess.

Pregnancy in Adolescent patient with uncertain compliance with therapy

Severe illness

Cannot tolerate outpatient regimen

Failed to respond to outpatient therapy

Clinical follow-up within 72 hours of starting antibiotics cannot be arranged

HIV-infected

GENERAL MEASURES

Avoidance of sex until treatment is completed

Ensure sex partners are referred for appropriate eval/ Tx

Partners should be treated, irrespective of evaluation, with regimens effective against chlamydia and gonorrhea.

SURGICAL MEASURES

Reserved for failures of medical treatment &/or suspected ruptured adnexal abscess with resulting acute surgical abdomen

Inpatient treatment: Cefoxitin IV, cefotetan IV (or other cephalosporins such as ceftizoxime, cefotaxime, and ceftriaxone)

PLUS doxycycline orally or IV Therapy for 24 hours after clinical improvement

Doxycycline continued after discharge for a total of 10-14 days

Clindamycin plus gentamicin loading dose IV or IM Therapy for 24 hours after clinical improvement with doxycycline after discharge as above

Outpatient treatment: ceftriaxone plus doxycycline orally for 10-14 days Ofloxacin orally for 14 days plus either clindamycin orally or metronidazole

PATIENT MONITORING:
Close observation for fever, symptoms, level of peritonitis, white cell count, safe sex practices, education-particularly for Pt c PID

CCS- Depression

HPI: 40 yo executive male comes to the office c CC of HA. Later gives hx of financial

problem, starts crying. First pay attention to history for alcohol or recent drug use.

You should check HPI to see when these headaches started, is it recurrent? Has patient's energy level changed recently, etc.

R/O medical cause.

PE: complete

Labs: CBC- possibly WNL,

Chem-7, UA- WNL,

Alcohol and Urine Drug screening- Need to R/O drug use.

TSH- probably WNL- rule out thyroid problem.

If all above = normal, have ruled out Medical cause

Depression index- response to 20 questions indicates depression.

Start antidepressant- if patient is obese use Celexa, otherwise any SSRI (prozac, zoloft)

Schedule psychotherapy (with psychiatrist) to augment medication.
Schedule patient for follow-up in 3 weeks.

CCS- Chron's disease

HPI: 28 y/o female comes to office c/o non-bloody diarrhea for several days.

PE: Complete

Labs: CBC- check for leukocytosis

Chem7

Guiaac

Stool culture- WNL

Stool for ova and parasites- WNL

Colonoscopy- biopsy- inflammatory process consistent c Chron's DZ.

Treatment: mesalamine, antidiarrheal (loperamide)

Reevaluate Pt in couple days...patient diarrhea has improved. Patient is feeling better.

See Pt in 2 weeks

Diagnosis: Chron's Disease

CCS- Sickle cell crisis

HPI: 6 Year old AAM brought to your office because of pain. Has Hx sickle cell dz

PE: Complete

Labs: CBC, Chem 7, Blood Type and cross

Treatment: pulse oximetry, O2, IV Fluid, morphine, exchange blood transfusion- if patient doesn't improve or Hgb is low. Folic acid

Immunizations: Haemophilus influenzae B and pneumoccal vaccines

Aminocaproic acid for hematuria

If recurrent CVA, chronic transfusion program,

Education, Counseling for family + pt.

CCS- Squamous Cell Lung Cancer

HPI: 67 y/o female, 30 yr cigarette history comes to office c/o cough.

PE:complete

Labs:Pluse ox, O2, CBC, Chem 7

CXR- mass on left upper lobe biopsy- sq. cell carcinoma

Surgical and Oncology consult

Diagnosis:sq. cell carcinoma.

You probably won't have time to do any kind of treatment because when you make the diagnosis case will end.

CCS- ASTHMA

HPI: 5yo child with acute asthmatic attack (coughing or wheezing..can't get air out)

Note vital signs: BP, Pulse, Resp. Rate, Temp.

Step I : Emergent management: A, B, C, D- O2 , broncodilators: Albuterol via MDI or nebulizer, depending on severity consider systemic IV corticosteroids.

Step II : Physical Examination: General appearance, HEET/Neck, Chest/Lung, Heart/CV

Step III :

Diagnostic Investigations:

1. O2 sat.
2. PFTs/ Spirometry
3. CBC
4. Chem 7
5. CXR
6. ABG- should be considered in severe distress of when FEV1 <30% of predicted values after initial treatment.
7. ECG

Treatment:

Have Pt SIT UP

1. O2 – warm , humidified 100% O2
2. ALBUTEROL (Beta-2 agonist) via MDI / Nebulizer q 20 mins
3. methylprednisolone IV q6h for first 24-48 hours then inhaled steroids

Step IV: Decision about changing Pt's location...

*Discharge home if symptoms resolve quickly or FEV1 is greater than 70% of predicted or personal best.

*Recommendation for hospitalization if:

1. response to treatment is poor
2. recent hospitalization for asthma
3. failure of aggressive outpatient management
4. previous life-threatening attack
5. If PEF or FEV1 (forced expiratory vol in 1 sec) is less than 50%
6. arterial CO2 tension > 42
7. If patient is confused/ drowsy
8. If no easy access to ER

If patient is D/Ced to home, need to return to office within 5-7 days for follow up.

Step V: Educate patient and family: Instruct patient/family to avoid triggers.

Instruct proper use of MDI / home nebs

STEP VI: Final Diagnosis: Acute Asthma Attack

CCS- Nortryptiline Toxicity (=Antidepressant: Serotonin-Norepi. Reuptake Inhibitor)

HPI: 27 yo female, found unconscious c Rx pill bottle.

***FIRST...ensure ABCs

PE: Heent/Neck, skin, CV, Lung, ABD

Labs: CBC, Chem13, Pulse Ox, EKG, ABG, drug level

Treatment:

Gastric lavage,

Activated charcoal c intermittent gastric suctioning

Induce alkalization c NaHCO3 (sodium bicarb.) to maintain pH of 7.45 to 7.55

If he is intubated, hyperventilate to PCO2 < 35 and > 25 mmHg

Foley Cath.

If nl ECG normal and asymptomatic, observe for 6 hrs in ER

Otherwise, admit to ICU

After ICU Admission, ECG should be normal for 24hrs to discharge for psychiatric disposition

CCS- Sickle-cell crisis (office)

HPI: 6 yo AAM brought to your office because of pain. Has Hx of sickle cell disease.

PE: Complete

LABS:

Blood smear

Hb electrophoresis

BUN & Cr
LFTs
Electrolytes
X-Ray skeletal

TREATMENT:

pulse ox , O2, IV Fluids, morphine, blood type and cross, exchange blood transfusion
hydroxyurea
Penicillin V 125mg bid up to age 3; then 250 mg bid up to age 5
Folic acid
immunization: H.influenzae B and pneumococcal vaccines
Aminocaproic acid for hematuria
If recurrent CVA, chronic transfusion program, Bone marrow transplant

CCS- COMMUNITY ACQUIRED PNEUMONIA

HPI: 64 Year old WF comes to your office c/o several days of cough.

PE:complete

Labs: CBC - leukocytosis with an immature LEFT shift on differential

Chem 7- hyponatremia (SIADH)

ABG – hypoxemia

Sputum Gram stain, Cx/sensitivity

Blood Cx

IMAGING: DIAGNOSE c CXR- (get lateral decubitus views if + pleural effusion)

See New pulmonary infiltrate in context of:

Fever, Resp. Sx (possible cough, sputum prod., dyspnea, pleurisy)

TREATMENT:

OUTPAT care for mild case c PATIENT MONITORING

For Community-acquired, PEN G for Strep Pneumo

Daily assessment of the Pt's progress, Reassessment of therapy if clinical worsening or no improvement in 48-72 hours.

Reduce risk factors where possible (quit smoking)

Annual influenza vaccine for high risk individuals

INPAT for moderate to severe case such as hypoxemia, altered mental status, hypotension, significant co-morbid illness, and age extremes.

For Nosocomial Orgs: Gram – Bacilli and Staph Aureus

Empiric Tx c Gram Negative coverage:

Cephalosporin(ceftriaxone/cefuroxime)

+Macrolide (azithromycin/EES)

Oxygen - for patients with cyanosis, hypoxia, dyspnea, circulatory issues,delirium

Analgesia- for pain

Electrolyte correction

CCS- APKD (adult polycystic kidney dz)

HPI: 32 yo male for routine check up.

PE: complete

LABORATORY:

CBC- Hematocrit - elevated in 5% of cases

Urinalysis - may have hematuria and mild proteinuria

Chem 7- Serum creatinine may be elevated

Kidney U/S - stones usually calcium oxalate

IMAGING:

Ultrasonography:> 5 cysts in the renal cortex or medulla of each kidney, in children, 2 or more cysts in either kidney

CT scan-more sensitive

85% of patients can be detected by age 25

TREATMENT: Outpatient-except for complicating emergencies (infected cysts require 2 weeks IV antibiotics then long-term oral antibiotics)

GENERAL MEASURES: Bed Rest and Analgesics for Pain

ACTIVITY: Avoid contact activities that may damage enlarged organs.

DIET Low protein diet may retard progression of renal disease.

PATIENT EDUCATION - Avoidance of nephrotoxic drugs

Genetic counseling = critical

Treatment: No drug therapy available for polycystic kidney disease

Hypertension - ACE inhibitors ONLY

*****avoid diuretics (possible adverse effects with cyst formation)

CCS- Cystic Fibrosis

HPI: 7 month old WF c foul smelling stools, recurrent episodes bronchiolitis

PE: General appearance, Heent/Neck, skin, chest/lung, heart/CV , Abdomen

Labs: CBC, Chem-13, Cl sweat test (Cl>60mEq/dl dgn)

CXR, PFTs, ABG, Sputum Cx/Sensitivity

Treatment:

Antibiotics if signs of infection –IV ceftriaxone+gentamycin for pulm.infections (IV Semi-synthetic Penicillin or Ceftazidime = Anti-pseudomonas aeruginosa Cephalosporin)
Albuterol MDI- B-2 agonist = Bronchodilator
Chest physiotherapy: postural drainage + percussion breathing exercise
Vigorous coughing exercise program
Pain meds PRN
Nutritional support: high calorie diet, oral pancreatic enzymes, vitamin A,D,E, K

CCS-Child Abuse

HPI: 4 y/o boy brought to ER for evaluation by mom.
ORDER SHEET:
Skeletal Survey
Urinalysis
CBC with differential , Serum Creatinine, Serum Blood Urea Nitrogen, Bilirubin
PT, PTT, bleeding time
CXR
Electrolytes
If sexual abuse concern: cultures of mouth, rectum, vag/urethra, VDRL
Ophthalmologic consult for retinal hemorrhages
ADMIT to WARD
Diet: Full regular diet
Social Worker Consult
Child Protective Services Agency report to local authorities (state protection agency)
DISCHARGE: When child = healthy, assure safety and that hospital knows his destination.

CCS- ATN

HPI: patient after MVA had developed decreased urine output.
Labs: CBC, Chem7, UA ,CPK
Treatment:
1. IVF with NS
2. Diuresis with Lasix
3. Sodium bicarb.
Patient improves.

CCS- ovarian cancer

33 yo WF lady c abdominal mass, ascities, stable vitals or mild resp distress due to pleuraleffusion (Meig's)
Labs: CBC, Chem7, UA, ESR,LFT, FOB(fecal occult blood),CXR, abdominal US
Following US, if mass detected, CT for metastasis

SURG/ONC consult

Laposcopic Biopsy of the mass- adeno CA or benign

if adeno- do debulking paracentesis

if severe symptomatic lateral decubitus >10mm, Do thoracocentesis

Follow up CBC

Counsel

CCS- Premature labor(Office)

26 y/o 32 weeks gestation presented with two 30 sec contractions in 10 minutes cervix 3 cm dilated. Effacement 70% .Transfer to Ward.

Labs: CBC with differential.

US for fetal size, position, placental location.

Amniocentesis for equivocal fetal maturity

UA, urine culture (urine obtained by catheter)

Electrolytes

Serum glucose

Treatment: bed rest, hydration

If this fails, TOCOLYSIS c:

Magnesium Sulfate/ritodrine

Glucocorticoids for lung maturity

*Note Contraindications for tocolysis:

ruptured membranes, cervical dilation>4 cm,

effacement >80%, fetal death, fetal distress, IU infection, polyhydramnios, IUGR,

erythroblastosis, severe maternal HTN, maternal pulmonary/cardiac disorders,

abruptio placenta, placenta previa.

CCS-Trichomonas vaginitis (Office)

24 y/o female complaining vaginal discharge and itching.

Labs: CBC Chem7 wet mount (saline and KOH) test to identify the organism (pseudohyphae=c.albicans vs fish odor=G.Vaginalis)

DX of Trichomonas:

pruritis, fishy odor , gray or yellow-green discharge, pH>4.5.

Treatment: metronidazole 2gm x1 and treat partner

At DC counsel pt. for Safe Sex.

CCS- Colon cancer

History of present illness: 60 year old male presenting to office for regular checkup.

VITAL SIGNS-

BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)

Allergy: NKA

Step I : Emergent management: A, B, C, D-Not needed

Step II : Physical Examination Complete-

General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III : Diagnostic Investigations:

1. CBC

2. UA

3. Chem-12

4. Lipid profile

5. Because of his age he needs GUAIC stool, If positive followed by colonoscopy. Result will show evidence of colon cancer.

6. Liver function tests, Chest x-ray to look for metastatic disease.

Step IV: Decision about changing patients location

1. After initial workup admit patient for elective surgery.

2. Surgery consult.

Get type and cross, CBC, Chem 12, EKG, CXR, PT, PTT, LFT, inform consent, NPO, and CEA level prior to surgery.

STEP V: Educate patient and family:

After surgery patient should be evaluated every 3-6 months for 3-5 yrs with history, physical examination, fecal occult blood testing, liver function tests, and CEA determinations. Colonoscopy is performed within 6-12 months after operation to look for evidence of recurrence and then every 3-5 years.

Step VI: Final Diagnosis: Colon Cancer

CCS-Turners syndrome

Mother brings in her 16 yr old girl with no menstruation .

Normal physical(Genitalia)exam

1. No need for ABCs as this is office visit for routine check up

2. Physical- complete, you will get the webbed neck, widely spaced nipple, short stature, lack of breast development

3. LABS

CBC, Chem7, UA,

CXR- pulmonary hypoplasia

ECG- COARCTATION OF AORTA,

BP different in arms

ECHO- COA, bicuspid aortic valve

Abd US- horseshoe kidney

Karyotype- XO

4. Reassurance, f/u in 2 weeks in office

If confirmed- < 12 yrs- growth hormone im injection+steroids

>12 yrs-est+prog (hrt)

Counsel

Consult cardio/urology/gyn(for streak ovary removal)

Follow Up in 4 weeks

CCS-Alzheimer's Dementia

Affects 15% of people over age 65. Occurs in Down's syndrome pts at younger ages (30-40). Gradually progressive, neurofibrillary tangles. Alzheimer's Disease: senile degenerative dementia (50%-90 of dementia pts) - Loss of cortical tissue (cerebral atrophy) with increased senile plaques. Criteria for the clinical diagnosis of probable Alzheimer's disease * Dementia established by clinical examination and documented by the Mini-Mental State Examination, include: Blessed Dementia Scale, or some similar examination and confirmed by neuropsychologic tests. Deficits in two or more areas of cognition. Progressive worsening of memory and other cognitive functions No disturbance of consciousness * Onset between ages 40 and 90, most often after age 65 * Absence of systemic disorders or other brain diseases that could account for the progressive deficits in memory cognition

Lab Orders: CBC, Chem 12, TFTs, PRP(to r/o neurosyphilis) all normal.

UA toxicology -ve.

CT: Evidence of cerebral atrophy with progression documented by serial observation

MRI shows changes highly suggestive of Alzheimers - tangled spaghetti patches. Certain dx: not until autopsy - on PM see structural changes, abnormal proteins in brain biopsy.

See shrinkage < neurons in cognitive areas of brain.

Early Signs: subtle loss of memory. Personal neglect, dec. in ADL. Gradual loss continues. Loss of communication skills. Later: ultimate loss of short and long term memory. Normal life span. May have good physical health.

Med Intervention: No real medical therapy. Nursing support primary.

Med Rx:

Donepezil (Aricept) 5-10 mg tablet /day Tacrine (Cognex) Not a cure. Does not appear to stop progression as was hoped. Acts to increase amount of acetylcholine in brain to improve memory. Helps to improve in a minority of patients. Side effects: Hepatic failure, GI, abd. Pain, skin rash.

Rivastigmine tartrate (Exelon) 6-12 mg cap/day

Premarin for ladies

Multivitamins 1 tb qd po

Aspirin For vascular dementia

Other supportive med Rx therapy for agitation: antidepressants, antipsychotic, sleeping aids.

Nursing focus: Safety, Help maintain function as long as possible, Care for caregiver.

Continuing Care: Medicare doesn't cover custodial long term. Must become impoverished to go on medicaid.

Few families able to cope with entire trajectory of the illness. Nursing home care essential for some.

As for Alzheimer: Remember, on the exam, whenever you counsel it takes 5 minutes for it. —

Social services consult- counsel no driving, advance living will- reassure patient/family-
counsel medical alert bracelet

CCS- Hypothyroidism (office visit)

History of present illness:

A 55 year old black woman with fatigue, weight gain, loss of Hair lateral third of eyebrow, obese and other nonspecific signs/symptoms presented to office.

Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

Step I: Emergent management: A, B, C, D- Not needed.

Step II : Physical Examination

General appearance, HEENT/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Neuro.

Step III : Diagnostic Investigations:

CBC

TSH (don't jump right away to whole thyroid function test as tsh is cost effective compared to whole thyroid panel....if tsh comes abnormal then do whole thyroid panel).

Thyroid Panel

Chem 12

EKG – To rule out Cardiac disease. Patient with cardiac diseases should be started on low dose (25 Mcg) and monitored closely.

lipid profile- patient is obese and at risk for CHD.

Treatment:

levothyroxine – Plasma TSH should be measured 2-3 months after initiation of therapy.

Step IV: Decision about changing pt's location

Move patient home with follow-up appointment in 4 weeks.

Stool guaiac as part of yearly exam in this old pt.

Pap smear is due or have not been done.

Step V: Educate patient and family:

Advised patient on low cholesterol, low fat, and low Na (high bp) diet, exercise program, etc.when 5min left screening warning, ordered repeat TSH in 4 weeks (to make sure, it is going down).

Step VI: Final Diagnosis: hypothyroidism

CCS-Gastric Cancer

67 y/o lady with HX of fatigue (Dyspeptic symptoms with weight loss)

VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)

Allergy: NKA

Step I: Emergent management:

A, B, C, D-Not needed

Step II: Physical Examination

Complete- General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro

Step III: Diagnostic Investigations:

1. CBC (Iron Deficiency Anemia)

2. Peripheral Smear

3. RI

4. TSH

5. Chem-7

4. Occult blood test stool (+++): because of her age she needs to go directly to:

Step IV: Decision about changing patient's location

Transfer Patient to Medical Ward (Colonoscopy is a hospital procedure)

1. Emergent Lower colonoscopy and work based on the result (here will be -)

2. Emergent upper endoscopy with cytologic brushing and biopsies (adeno cell Ca)

3. LFT (metastasis)

4. Abdominal CT for identifying distant metastases.

5. Pre op workup such as blood type/cross match, CXR, EKG, PT, PTT, BT, start iron, Zantac.

6. Consult Surgery/Oncology/: Message surgery will be available shortly

DO interval/brief physical exam

STEP V: Provide counseling from the list (Pt/family/advance directive)

Case will end here

Step VI: Final Diagnosis: Gastric Cancer

CCS-Folic Acid Deficiency Anemia (Office)

History of present illness: A 52 year old man comes to office complaining fatigue. He has a history of drinking.

VS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)

Allergy: NKA

Step I : Emergent management: A, B, C, D- Not needed.

Step II : Physical Examination General appearance, HEET/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Rectal, Neuro.

Step III : Diagnostic Investigations: CBC/Diff (MCV > 110), Leukopenia, thrombocytopenia .Peripheral Smear- anisocytosis, poikilocytosis and macro-ovalocytes, hypersegmented neutrophils.RITSH (Ultrasensitive) Occult blood test (-)
Chem 7, LFT- LDH and bilirubin may be elevated Lipid profile- if patient has risk factor
Order Folic acid (low/ B 12 level)- serum B12 and RBC folate levels. if level equivocal do Homocystine level.

Initial Treatment: Start Folic Acid Continuous Multivitamin daily

Message: pt is feeling better

Do Interval History and physical exam

Step IV: Decision about changing patients location- Move patient home

Schedule FU in 1 week

Refer for Substance abuse evaluation

Step V: Educate patient and family:Quit Alcohol/Smoking, + Exercise program, Advance directive

Case will end here

Step VI: Final Diagnosis: Folic Deficiency Anemia

CCS-Erosive Gastritis

History of present illness: 55 yr old African American pt with history of Arthritis/chronic aspirin therapy presented to office with c/o fatigue

VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F) Allergy: NKA

Step I: Emergent management: A, B, C, D-Not needed

Step II: Physical Examination Complete- General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III: Diagnostic Investigations:

1. CBC (Normocytic Normochromic Anemia)
2. TSH
3. Chem-12
4. Occult blood test stool (+++): because of his age he needs to go directly to:
5. Colonoscopy (-) followed by endoscopy (++) for gastric ulcer, no evidence of malignancy)
6. D/C ASA
7. Start Acetaminophen, Zantac
8. from the counseling list: Quiet smoking
9. from the counseling list Quiet alcohol
10. Advanced directive

Step IV: Decision about changing patient's location

Home with 2 weeks follow up

Pt comes feeling better

Do Interval history and physical exam

Repeat CBC only

STEP V: Educate patient and family: and case will end here

Step VI: Final Diagnosis: Erosive Gastritis

CCS- Transient Ischemic Attack (ED)

History of present illness: Patient 54 years old with a hx of Hypertension, hypercholesterolemia, smoking and DM . wife brought her husband because he dropped a plate on the floor & he was unable to understand what she was saying, she asked him to write, he wrote couple of sentences that didn't make any sense, episode lasted few hrs. she brought her husband to ER.

Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F) Allergy: NKA DX:TIA, Thrombotic or embolic stroke.,Subdural hematoma Seizure

Step I : Emergent management: A, B, C, D- Not needed.

Step II : Physical Examination General appearance, HEET/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Neuro.Physical: BP 170/98 P 100A loud bruit was auscultated over left carotid, no murmurs, rubs or bruits were heard over pericardium. neuro was nonfocal.

Step III : Diagnostic Investigations: Initial Test:1. CBC 2. Chem-6 3.CT- (remember CT takes about 2hrs, is this patient stable enough to send to CT(YES), are there any other tests(blood tests) you should do before you send him to CT. Think reason before you do a test, do not write all possible tests you could do . "Save cost, do less invasive tests, save time, be focused on that particular case, effective decisions. If CT questionable, MRI is more accurate. Why do you do a CT in this case? To rule out hemorrhage! Will the hemorrhage show in CT?, in which time phrase? Hemorrhage will show within 24 hrs, but infarcts will take few days. Why do you want to exclude hemorrhage? There is a carotid stenosis, neurological deficit we want to think, to give anticoagulation to this patient, if there is a hemorrhage he will bleed more with anti-coagulation!

Test results: after 2 hrs, remember patient is in YOUR care for TWO hrs now!

CT: NEGATIVE

Diagnosis: Considering , HX, physical, & the test you have done: this patient has 'expressive aphasia left temp, because the deficit lasted only few hrs it is TIA. TIA by definition, deficit lasting <24hrs. CT scan most of the time will not show any deficits in first 24 hrs. There is a carotid bruit, might represent a plaque that sent a small embolus to the brain.

Step IV: Decision about changing patients location Admit to ward Further Diagnostic

Plan: 4. Carotid Doppler 5. Angiography 6. 24hrs Holter 7. Echocardiogram

Results: >70% stenosis- 77% stenosis, no arrhythmia, no valvular disease, no evidence of Thrombus Treatment Plan:1. Antiplatelet- Aspirin 2. Heparin 3. Vascular surgeon consult for elective CEA- A Multidisciplinary Consensus Statement from the American Heart Association concluded that carotid endarterectomy is of proven benefit for symptomatic patients, including those with single or multiple TIAs or those who have suffered a mild stroke within a 6-month interval, who have stenosis of greater than 70% with a surgical risk of less than 6%. 100% stenosis ; NO CEA-causes hyperperfusion

StepV: Educate patient and family:Stop smoking Better BP control-(exercise, diet, Pharma.....)DM control (exercise, diet, pharma) Continue aspirin or plavix

Step VI: Final Diagnosis: Transient Ischemic Attack.

CCS- Narcotic Overdose (ED)

History of present illness:25-yr- lady brought in unconscious with bradycardia, hypotensive and pinpoint pupils classic case of narcotic overdose.

Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F) Allergy: NKA

Step I : Emergent management: A, B, C, D

A: Airway suction, Pulse Ox Q 1 hr or continuous monitoring, O2

B: Endotracheal intubation in O2 sat. does not improve with O2 nasal or $\text{PaO}_2 < 55$, or $\text{PCO}_2 > 50$,

C: IV access (KVO), cardiac monitor, catheter Foley, finger stick glucose

D: Drugs: thiamine, dextrose 50% and naloxone-all are IV bolus one time dose

Step II : Physical Examination General appearance, HEET/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Neuro.

Step III : Diagnostic Investigations: 1. B-HCG

2. ABG

3. CBC

4. Chem 13

5. PTT/PT

6. EKG 12 lead

7. CXR portable

8. UA, UDS, BAL, Barbiturate level(level > 80-100 causes coma), blood aspirin and blood acetaminophen level.

Initial Treatment: Order gastric lavage, get result (which revealed pill fragments)

Order Activated Charcoal

Start naloxone drip,

If evidence of BZD use, give flumazenil.

Alkalinization of the urine is useful with phenobarbital and barbitol overdose

Interval HX on brief physical

Step IV: Decision about changing patients location: Move patient to ICU

Check lytes again, DC Intubation if patient has improved, DC NG Tube

Continue cardiac monitoring/pulse ox 24 hrs

DC Naloxone

Step V: Educate patient and family: Psych consult (result will tell, the hx consistent with suicidal attempt)

Order suicide precautions, Move pt to ward, basically the Psych ward DC IV line Start regular diet, Start patient on Antidepressant

Step VI: Final Diagnosis: Narcotic overdose

CCS- Acute Pericarditis (ED Setting)

History of present illness: 45 year-old lady with substernal chest pain, Hx of previous URI

Orders: O2, IV Line (KVO) Cardiac monitoring, pulse monitoring

Physical Examination: General Appearance, HEET/Neck, Extremities, Chest/Lung, Heart/CV

Diagnostic Investigations: O2 saturation, EKG (ST elevation in all leads), Cardiac enzymes, Troponin I (neg), Chem 7 (WNL), CXR Portable (WNL), ABG (WNL), CBC

Treatment: Start ASA continuous (can use indomethacin or in severe cases corticosteroids)

Next order ECHO in ER (result was some fluid, but not severe)

Next DC O2, Monitor

Next Reassurance, Educate patient and family

DC to home and F/U in office.

Final Diagnosis: Acute Pericarditis

CCS- Solitary Pulmonary Nodule (office)

Solitary Pulmonary Nodule (office)

History of present illness: 55 year-old smoker male with history of blood in the sputum

Note VS: BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

Step I : Emergent management: A, B, C, D- Not needed.

Step II : Physical Examination Complete Physical Examination

Step III : Diagnostic Investigations:

CBC, Chem 7

Sputum: Gram stain. AFB, C&S PPD

CXR PA/L Nodule in the R U Q

Lung Spirometry

EKG

Pulse OX

Next order in the office Chest CT (it will give you the size of the nodule 2.5 mg)

Next consult surgery: Bronchoscopy and biopsy (result was SqCell CA)

Order now LFT, Head Ct, Blood type/cross match

Step IV: Educate patient and family: Stop smoking

Step V: Final Diagnosis: Solitary Pulmonary Nodule

Case ends here

CCS- Active Tuberculosis

TB (Sudan immigrant Case): office

History of present illness: 55 yr old immigrant psychiatrist came in with classical symptoms of pulmonary TB

Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

Step I : Emergent management: A, B, C, D- Not needed

Step II : Complete Physical Examination

Step III : Diagnostic Investigations:

Order the following:

1. CBC
2. PPD
3. Chem. 12,LFT
- 4.UA
5. Sputum smears AFB
6. Sputum TB culture and PCR test(result will be ready by PCR within 24 hrs)

Now get the results of (AFB was negative. PCR came positive after couple days).

Order CXR and the result was (upper apical infiltrate/cavity).

Now you need to decide to admit or treat as an outpatient (remember hospitalization for the initial therapy of TB is not necessary in most patients)

Step IV: Decision about changing patients' location

Treatment plan:

1. Notify the health dept.
2. Start treatment with 4 drug regimen: INH, Rifampin, Pyrazinamide, and either Ethambutol or Streptomycin
3. Weekly sputum smear and cultures and then monthly once they test negative.
4. Ordered f/u appt with f/u sputum study.
5. influenza/pneumonia vaccine, multivitamin
6. HIV Test in all pts with TB

Step V: Educate patient and family: Counseling and Education.

Step VI: Final Diagnosis: Active Tuberculosis

CCS- G6PDD

History of present illness: young boy present with pallor, jaundice and splenomegaly.

Recent history of URI treated with Bactrim(sulfa).

First note vital signs – make sure patient is stable.

Step I : Emergent management: Not needed.

Step II : Physical Examination General Appearance, skin, lymph nodes, HEENT/Neck, Chest/Lungs, Heart/Cardiovascular, Abdomen, extremities, Neuro.

Step III : Diagnostic Investigations:

HPI described a patient with splenomegaly, anemia, and jaundice. Patient was treated with bactrim few days prior to presentation which makes you think of G6PD. Patient should be workup for anemia especially G6PD.

1. CBC/D- will show Normochromic Normocytic Anemia

2. Peripheral Smear- Heinz bodies (bite cells) only seen on crystal violet staining of peripheral Smear. Will not be seen on wright-stained blood smear.

3. reticulocyte index >3% (reticulocytosis)

4. LFT- Serum bilirubin elevated

5. Urinalysis- Hemoglobinuria

6. Erythrocyte G6PD Assay- Low enzyme level.

7. Type and cross- If hemoglobin is low- severe cases may need transfusion

Treatment: Stop Bactrim

IV Access and IV fluid-NS

Step IV: Decision about changing patients location

Admit to ward Continue IV fluid until diagnosis is established and patient has improved.

If evidence of infection – Treat with non- sulfa drugs

When patient is stabilized Cancel IV and Move patient home.

Step V: Educate patient and family: Console patient on food and medications that can cause problem

1. seek medical attention for any infection

2. avoid foods containing fava beans

3. Avoid Medications including: acetanilid, dapson, Bactrim, nitrofurantoin, sulfacetamide, sulfamethoxazole, sulfonamide, sulfapyridine doxorubicin, methylene blue, nalidixic acid, naphthalene, phenazopyridine, phenylhydrazine, primaquine, quinidine, quinine, on ccs you may not have option to console patient for specific food or drug use, just select console patient!

STEP VI: Final Diagnosis G6PD

CCS- Panic Attack

History of present illness: A young man with Palpitation, pounding heart, anxiety comes to ER for evaluation. Whenever a patient, regardless of age or risk factors, reports to an emergency room with symptoms of a potentially fatal condition i.e MI, a complete medical history must be obtained and a physical examination performed.

DDX is numerous including: cardiovascular d/o, Pulmonary diseases such as asthma, Neurological diseases, endocrine disorders, Drug intoxication, Drug withdrawal such alcohol, and Anaphylaxis.

VITAL SIGNS- make sure patient is stable- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

Step I : Emergent management: Not needed. Unless respiratory distress is present.

Step II : Physical Examination General Appearance, skin, HEENT/Neck, Chest/Lungs, Heart/Cardiovascular, Abdomen, Neuro.

Step III : Diagnostic Investigations: Following labs will eliminate any possible cause. With normal tests, panic attack is diagnosed. Presence of atypical symptoms such as vertigo, loss of bladder control and unconsciousness or the late onset of the first panic attack >45 years old require further evaluation.

1. O2 SAT. Ashtma, COPD.

2. CBC- rule out anemia, Infection

3. Chem 12- electrolyte abnormalities(glucose, Ca, BUN, Cr).

4. TSH- Hyperthyroidism

5. LFTs

6.UA

7. Urine Drug screening

8. EKG Treatment: Usually not needed but can use Xanax 0.5mg once.

Step IV: Decision about changing patients location

1. If All test results are Negative and patient is stable, Move patient home. Schedule office appointment

2. If patient continues to have panic attacks at a later time/date, consider drug treatment with Benzodiazepines, SSRI, TCA, MAOIs, Treat for 8-12 months. Consider adding cognitive and behavior therapies as combination is superior than either one alone. SSRI are considered the initial drug of choice i.e sertraline.

Step V: Educate patient and family: Avoid caffeine and medications that can cause panic attack including: yocon, pondimin, flumazenil, cholecystokinin, and isuprel.

STEP VI: Final Diagnosis - Panic Attack

CCS- Tension Pneumothorax

65-year-old white man with chest pain

Case Introduction: Essential Facts:

Patient is white, in mid-sixties

- Has sharp, right-sided chest pain, accompanied by respiratory distress • He was brought to the emergency department

Comment: There is no connection between being white + having chest pain. This patient could have been of any racial origin and still present with these clinical features.

However, the patient's age will affect our choice of differential diagnoses. Chest pain in an older man is more likely to be of cardiac origin than the same pain in young patients.

Possible differential diagnoses at this stage include:

Pulmonary embolism (PE) because of chest pain

Respiratory distress

- Lobar pneumonia (chest pain, respiratory distress)
- Tension pneumothorax (chest pain, respiratory distress)
- Musculoskeletal chest pain (pain in a specific location)
- Pleuritic chest pain
- Cardiac pain (this is less likely, though possible. A patient with dextrocardia who develops myocardial infarction may have right-sided chest pain. However, since this test is based on clinical conditions commonly seen in practice, we are not going to be too concerned with this differential)

Initial Vital Signs: Essential Facts•

There is tachypnea and tachycardia

- Blood pressure is low
- Temperature is normal
- The patient is obese (BMI of 29)

Comment: Pneumonia as a cause of this patient's chest pain is effectively ruled out because of the normal temperature. Still high on our list are PE, pneumothorax, and the other differentials listed above. Patient's obesity will be addressed at a later time.

Initial History: Essential Facts

- Chest pain began 10 minutes before arrival at the ER
- This is the first episode of chest pain
- Patient has had chronic lung diseases that may predispose to pneumothorax
- Chest pain increases with respiration
- He was not involved in strenuous activities immediately before the onset of chest pain

Comment: Although, this pain increases with respiration, a musculoskeletal cause is unlikely, going by the patient's recent history. He is an accountant who suddenly developed an excruciating chest pain while at work. There is no recent history of chest trauma. Because of his long-standing history of asthma and emphysema, we will add emphysema to his differentials, since the latter can cause a measure of chest discomfort,

CCS- Tension Pneumothorax ,ctd

especially if there is associated chronic obstructive pulmonary disease (COPD).

However, uncomplicated emphysema does not cause sudden sharp chest pain.

It is time to perform the physical examination.

Click the button labeled Interval History or PE and select:

- General Appearance• Chest/Lungs and • Heart/Cardiovascular

We are interested in the general appearance (this is standard when interacting with most patients. You should always examine the patient's general appearance). Moreover, because the primary complaint is in the chest region, we would naturally want to examine that area. Also, considering the patient's age and the possibility that his heart might be the cause of his problems, we want to examine the heart as well. We cannot do more detailed examination of other systems because this is an emergency.

Press OK to confirm your choice.

History and Physical: Essential Facts:

- Patient is cyanotic and in marked respiratory distress • There is chest asymmetry, with hyper-resonance on right side. Breath sounds are also absent on that side • Cardiac examination essentially normal • Peripheral pulses present but weak

- No pulsus paradoxus (a fall in pulse amplitude with quiet inspiration)

Comment: Notice the results of physical examination. We seem to have enough reason here to believe that this patient has tension pneumothorax. However, we would still like to confirm this with further tests.

FAQ: Since this patient is in severe pain, and his vital signs are abnormal, why can't we just go ahead and treat?

Answer: Although this is a relative emergency, it is clear that we have enough reason to investigate the cause of the patient's problems further before we initiate treatment. First, we can still measure his blood pressure (although this is low). There is no pulsus paradoxus. We are not going to waste time on nonessential investigations however. It is important to try and establish the cause of patient's problems, if possible, before we initiate treatments.

Now, write orders.

If the result of the History and Physical is still visible, click OK to close it.

Next, click the button labeled Write Orders or Review Chart.

Next, click Order button at the bottom of the screen, and enter the following orders (one on each line):

- Chest x-ray
- Oxygen
- Morphine
- ECG

Confirm the orders by clicking the Confirm Order button.

For chest x-ray order verification, choose Chest x-ray, portable.

Click OK.

Urgency: stat.

CCS- Tension Pneumothorax ,ctd

Note: Although, Chest X-ray PA/lateral may give you more detailed information, it takes more time. Moreover, the patient has to be wheeled to the X-ray department before the films can be taken. Portable chest x-ray can be done right there at the ER, and it takes very little time.

For oxygen, choose Inhalation for route and Continuous for frequency.

For morphine, choose Intravenous for route and Continuous for frequency.

Note: morphine is almost always given through the intravenous route for most conditions.

In any situation where you have need to use morphine, consider this fact. Don't let the frequency that we chose mislead you. Continuous administration here means that it is given at fixed times (e.g. 6 hourly, 8-hourly, etc).

For ECG order verification, choose ECG 12-lead; Urgency: stat.

Now that we have initiated treatment, it is time to review that patient with the next available result. From our Order Sheet, we can determine that the result of the portable chest x-ray will be ready within 10 minutes.

So advance the clock to that time.

Click the button Obtain Results or See Patient Later at the top of the screen, and choose Review Patient with Next Available Result.

The test result is displayed.

Chest X-ray findings: Right tension pneumothorax

Next, we are going to write more orders for this patient.

Click the Order button at the bottom of your screen and type thoracentesis.

Scroll to the bottom of the form and choose Thoracostomy tube.

Confirm your choice. The result of this procedure is immediately displayed.

When you click OK, the result of the 12-lead ECG will be displayed, showing essentially normal findings.

It is now time to advance the clock, so we can re-evaluate our patient in 15 minutes.

Click on the clock at the top of the screen and choose

- Re-evaluate case In, then
- type 15 in the Minutes box (you may also use the upward pointing arrow to do this).

Click OK

Now that our patient has been stabilized, we would like to perform an interval follow up before we admit him for further management.

Towards the left side of the screen, click Interval History button, and choose

- Interval Follow Up,
- Chest/Lungs under the Physical Examination section

The important findings this time are:

- Patient is a smoker (for 45 years)
- He has a positive family history of cardiac disease, hypertension, obesity, and stroke.
- As noted earlier, the patient is obese (he has a body mass index of 29)
- Patient does not engage in regular exercise (dyspneic after 1 minute of brisk walk)

CCS- Tension Pneumothorax ,ctd

- The chest is now symmetrical

Some of this information will come in handy when it is time to address the patient's health maintenance issues. For now, we would like to send him to the ICU.

FAQ: Since the patient has been stabilized, why can't we just admit him to the ward instead of the ICU?

Answer: Under the British medical care system (and, incidentally, this is also true of many third world countries), we would have sent the patient to the ward. However, in the United States, patients like these are sent to the Intensive Care Unit.

FAQ: Why can't this patient be discharged home right away, since he has been relieved of his problems?

Answer: he has a chest tube in place. The general consensus is that the chest tube should remain in place until we are sure it is no longer needed (i.e it does not show any bubbles in the water seal.) Even then, some hospitals prefer to clamp the tube and observe for some more time, before they remove the tube entirely.

Click the Change Location button, and select Intensive Care Unit (ICU).
Confirm move. Recorded vital signs are displayed (much better this time around).
Click OK.

We must now add more treatment for the patient.

Click Order Sheet on the left side of the screen, and Order button at the bottom.

Enter the following orders (one per line):

- Albuterol (inhalation, continuous)
- Atrovent (inhalation, continuous)
- Advise patient, smoking cessation (routine, start now)
- Advise patient exercise program (routine, start later)
- Advise patient, weight reduction (routine, start later)

Next, we are going to re-evaluate the patient in 1 day. Click the clock, and advance the next evaluation to 1 day. The dialog appears telling you you have five minutes more, and asking for the final diagnosis.

Final diagnosis: Tension pneumothorax

End of case

CCS- Cardiac Tamponade

History of present illness: 59 year old man involved in MVA, chest impacts the steering wheel, comes in with distant heart sounds, dyspnea, obtunded.

Vital signs- BP, Pulse, RR, Temp.

This patient requires Step I with ABCD.

With Steering wheel injuries one should be concerned about fracture of sternum, ribs, trauma to lungs, spleen, Liver, and myocardial contusion.

Distant heart sounds give you the clue to possible pericardial effusion.

Signs of cardiac tamponade include:

distended neck veins, decreasing blood pressure, narrowing pulse pressure, muffled heart sounds, pulses paradoxus, and equalization of hemodynamic pressures (CVP).

Step I : Emergent management: A, B, C, D- Supplemental oxygen , Cardiac monitoring, Intravenous access

Step II : Physical Examination- General appearance HEENT/Neck- check for distended neck JVD/Heart/CV- Distant heart sounds Chest/Lung, Abdomen, Extremities, Neuro.

Step III : Diagnostic Investigations:

1. EKG- electrical alternans
2. CXR
3. Echocardiography- the most sensitive and specific noninvasive test for the presence of fluid in the pericardium.

Treatment:

1. IV Fluid
2. Pericardiocentesis
3. If vital signs are lost in ER, an immediate thoracotomy is indicated.
4. Consult for thoracotomy
5. Presurgical workup- CBC, BMP, CXR, PT, PTT, EKG, Type and cross match, IV antibiotic.
6. Urine drug screening
7. BAL

Step IV: Decision about changing patients location After surgery transfer patient to ICU and monitor EKG, repeat CXR and complete physical exam. When patient is stable, move to ward, then move home.

Step V: Final Diagnosis: Cardiac Tamponade

CCS- HEAD INJURY

HEAD INJURY

History of present illness: An 18 year old white male fell to the ground while playing soccer and was unconscious for 2 min. He is complaining of HA but cannot recall the incident. His friends state that after the time of injury, he has difficulty walking.

VITAL SIGNS- Check vitals to make sure pt is hemodynamically stable. BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

DDX: 1)Concussion 2)Contusion 3)Epidural/Subdural Hematoma.

Step I : Emergent management: ABCD- if patient unstable O2, IV access

Step II : Physical Examination Focus: HEENT/Neck, chest/lungs Heart/CV, abdomen, Extremities, Neuro/Psych.

Step III : Diagnostic Investigations:

1. CBC
2. Chem-7
3. Type and cross match
4. Continuous monitoring of vital signs, oximetry, EKG
2. Order CT SCAN of head without contrast.
3. Move the clock and get results.

4. If CT Scan shows epidural or subdural hematoma and patient is stable get Neurosurgical consult for Emergent Evacuation of the Hematoma.
 5. If patient is unstable due to increased intracranial pressure do #4 and start IV mannitol. If not effective then...
 6. Intubate the pt. and hyperventilate to pCO₂ of 35mm Hg
- Step IV: Decision about changing patients location
1. Patient with Neurologic signs should have emergent surgery.
 2. Neurological check up every 1 hrs .
 3. Repeat CT after 24 hrs. If CT is Normal and patient is stable move home with office follow up in 5-7 days.
- STEP V: Educate patient and family: Patient with head trauma and initial normal CT should be informed to return to hospital Immediately if he develops Neurologic signs which requires Emergent CT.
- STEP VI: Final Diagnosis: Epidural Hematoma

CCS- Pneumocystis Carinii Pneumonia with Candida Vaginitis

History of present illness: 40 year old homosexual female, cough and fever, vaginal itching . Note where the patient is on presentation, if she is in your office after initial work up, patient should be transferred to Ward or ICU (depending on presentation but most likely to ward). Unless the symptom are mild in that case treat patient in the office.

VITAL SIGNS- will help you to determine if patient is stable or unstable. BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F) Allergy: NKA

DDX- Pneumocystis pneumonia- Top of your list because of risk factor and OI at presentation.

Cytomegalovirus
Kaposi Sarcoma

Legionellosis

Lymphocytic Interstitial Pneumonia

Mycoplasma Infections

Nocardiosis

Bacterial Pneumonia

Fungal Pneumonia

Viral Pneumonia Pulmonary

Embolism

Tuberculosis

Step I : Emergent management: A, B, C, D- depending on presentation and assessment of O2 sat. if O2 sat is low. Start with one liter O2 and get IV access.

Step II : Physical Examination Any suspect HIV/AIDS patient should have a complete physical exam. General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III : Diagnostic Investigations:

1. O2 sat.- Pulse oximetry is obtained as part of the initial workup
2. ABG- with signs of respiratory distress.(hypoxemia)
3. LDH- Levels are noted to reflect disease progression. High levels during treatment indicate therapy failure and worse prognosis.
4. CBC/Differential-
5. Chem-12
6. CXR- The classic finding is diffuse central (perihilar) alveolar or interstitial infiltrates. Normal CXR is found in 5-10% of cases.
7. Sputum- by-sputum induction for Wright-Giemsa stain or direct fluorescent antibody (DFA) for Pneumocystis if PCP is strongly suspected. If negative and PCP suspicion is high next step is bronchoalveolar lavage.
8. HIV test- when you order a test like HIV that requires patient consent, it will tell you that patient consented to the test and result will be available in 7 days
9. CD4 count
10. PCR assay
11. Saline or KOH Vaginal secretion (wet mount).
12. LFTs
13. VDRL, Toxoplasma IGG, and hepatitis B and C serologies.
14. Cervical papanicolaou Smear
15. TB skin test.

Treatment: 1. IV fluid –NS (In moderate- severe cases).

2. If suspicions is high for PCP start treatment with Bactrim-DS po bid for 14-21 days. If patient is hypoxic, start with Bactrim IV. 3. Report positive result to Department of Health and Human services.

Step IV: Decision about changing patients location

1. Mild-to-moderate disease refers to patients with milder symptoms and a nontoxic clinical appearance. They generally are not hypoxic and may even have a normal CXR. Outpatient oral therapy can be considered for these patients.
2. Moderate-to-severe disease describes patients with severe respiratory distress, hypoxemia, and, often, a markedly abnormal CXR. Inpatient management with rapid diagnosis and treatment is essential.

3. Admit patient to ward for moderate to severe disease. (ICU if patient unstable). Mild cases should be managed outpatient.
4. Discontinue IV fluid if patient is taking po and is not dehydrated.
5. Continue Bactrim –
6. Treat Vaginal candidiasis with antifungal such as nystatin, clotrimazole, miconazole vaginally.
7. When diagnosis of AIDS is established start Antiviral therapy with: A. 2 NRTIs + 1 or 2 PIs. B. 2 NRTIs + an NNRTI
8. Vaccines: Influenza, Hepatitis A and B, Pneumococcal vaccine.
9. when patient is stabilized cancel IV fluid, move patient to home with follow-up in your office in 5-7 days.
10. Continue Bactrim and antifungal- discontinue antifungal when patient returns for follow –up unless symptoms still persist in that case consider changing antifungal.

Step V: Educate patient and family:

1. EDUCATE Safe sex.
2. Medication compliance.
3. COUNSEL Pt to join HIV support group. When you request this option it tells you arrangements for follow-up have been made.

Step VI: Final Diagnosis: Pneumocystis Carinii Pneumonia (PCP) with Candida Vaginitis

CCS- Sigmoid Volvulus

History of present illness: 63 years old man brought to Emergency Room complaining of colicky abdominal pain.

When reading HPI note following: VITAL SIGNS- make sure patient is stable- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

DDX- Bowel obstruction, -

Carcinoma Pseudo-obstruction (ileus)

Giant sigmoid diverticulum

Constipation

Step I : Emergent management: ABCD- Not needed

Step II : Physical Examination General appearance Abdomen- Examination reveals a tympanitic/distended abdomen, and a palpable mass may be present. Severe pain and tenderness suggests ischemia/perforation. Bowel sounds are usually absent. Rectal exam-

Rectal examination shows only an empty rectal ampulla. Skin, Chest/Lung, Heart/CV, Extremities, Neuro.

Step III : Diagnostic Investigations:

1. CBC- Leukocytosis (in some cases Leukocytosis may be absent)
2. Chem 7- to evaluate any electrolyte abnormality
3. X-ray of Abdomen- Diagnosis of sigmoid volvulus can be made by using plain abdominal radiographic findings Plain radiographs show a markedly distended sigmoid loop, which assumes a bent inner tube or inverted U-shaped appearance, with the limbs of the sigmoid loop directed towards the pelvis. Also dilated gas-filled lumen, can result in a coffee bean-shaped structure; this is the coffee bean sign.
4. If diagnosis is questionable Barium Enema will confirm diagnosis but is contraindicated in suspected perforation

Treatment: 1. IV access- IV Fluid with LR

2. GI consult- reason for consult, evaluation and decompression of possible sigmoid Volvulus.
3. Sigmoidoscopy- decompression and untwisting of the sigmoid loop with placement of long soft tube

Step IV: Decision about changing patients location

1. Admit to ward
2. Continue IV fluid
3. Monitor patient for 2-3 days after decompression for persistent abdominal pain and bloodstained stools, signs that may herald ischemia and indicate the need for surgical intervention.
4. Consult General surgery- Surgery is reserved for patients in whom tube decompression fails or for those in whom signs of ischemia are suggested. Surgery also has a role in an elective situation when the volvulus repeatedly recurs.
5. After patient is stabilized, move patient home with office follow-up in 5-7 days.

Step V: Educate patient and family: Counsel patient to seek medical care if Nausea, Vomiting , Rectal bleeding or abdominal pain recur.

Counsel: low fat, high fiber diet.

STEP VI: Final Diagnosis- Sigmoid Volvulus

CCS- DKA vs Hyperglycemic Hyperosmolar state

History of present illness: 25 yo woman, with abdominal discomfort and confusion (blood sugar over 600 mg/dL).

Note vital signs: BP, Pulse, Resp. Rate, Temp. Check vitals to make sure pt is hemodynamically stable. Is there History of diabetes? (new onset ?)

DDX: DKA vs hyperosmolar state

Step I : Emergent management: A, B, C, D- IV access followed by 0.9 NS (pt. with hyperosmolar and hypotension from hypovolemia use NS otherwise ½ NS is preferred because of marked hyperosmolar state) , IV insulin

Step II : Physical Examination General appearance, skin, HEENT/ Neck, Chest/Lung, Heart/ CV Abdomen, Neuro/Psych

Step III : Diagnostic Investigations:

1. CBC
2. Chem 12

3. FSBS (finger stick blood glucose)
4. ABG
5. UA
6. Serum ketones
8. Amylase and Lipase (usually positive in abd. Cause)
9. serum osmolality
10. EKG
11. HBG A1c

Treatment: 1. Continue IV hydration with NS until blood suger is around 250 mg% then consider D5 ½ NS. Change insulin to subq instead of IV.

2. Monitor potassium , phosphate and Magnesium. And replace.

Step IV: Decision about changing patients location

1. Patient need to admitted to ICU initially then to ward when stable
2. After patient is stabilized investigate the cause if is still unclear.
3. Discharge home with follow up visit

Step V: Educate patient and family: Educate patient on diabetic diet, exercise, signs of hypoglycemia

Final Diagnosis: Key points in differentiation between DKA and Hyperosmolar State:

DKA:

1. hyperglycemia >250 Mg/dl
2. Acidosis with blood PH< 7.3
3. Serum bicarbonate <15 meq/dl
4. serum positive for ketones

Hyperglycemic hyperosmolar state:

1. Hyperglycemia >600 Mg/dl
2. Serum osmolality >310 mosm/kg
3. No acidosis; blood PH above 7.3
4. Serum bicarbonate >15 meq/L
5. Normal anion gap (<14 meq/L).

CCS- Acute cholecystitis

History of present illness: 42 year old female was having lunch developed abd pain with nausea and vomiting.

Note: BP, P, RR, HR, quality of pain, duration of pain.

DDX-

1. Acute pancreatitis
2. Ulcer
3. Diverticulitis
4. Pneumonia
5. hepatic abscess
6. hepatic tumors
7. irritable bowel disease

8. Non- ulcer dyspepsia

9. Pancreatitis

Step I : Emergent management: Most likely not needed.

Step II : Physical Examination General appearance,Heent/Neck, skin, chest/lung, heart/CV , Abdomen

Step III : Diagnostic Investigations:

1. CBC w/diff. – (leukocytosis 12000- 15000) ,Chem12, amylase, lipase,LFT (Ast, Alt, and GGt will be slightly elevated), fasting Lipid profile.

2. Upright abdominal X-Ray (15% calcium stones)

3. USG if questionable do Tc-99m-IDA (HIDA)- if USG shows no stone and HIDA is positive consider Acalculous cholecystitis.

4. pregnancy test especially if result not clear or medication is to be given

Treatment: For patient who are sick enough to be admitted.

1. NPO

2. IV Fluid

3. demerol for pain

4. Nasogastric suction

Step IV: Decision about changing patients location

1. If mild can be treated outpatient with low fat diet and actigal

2. Admit If pain is >6 hour and showing toxicity, Jaundice, rigors, or requiring narcotics for pain.

3. Admit to ward

4. surgical consult- if no perforation or CBD obstruction

5. If surgery is to be done prepare with CBC, chem7, CXR, PT, PTT, cross and match, EKG

6. Antibiotics cefotetan, or clindomycin and gentamicin

7. When patient stabilized, DC to home

STEP V: Educate patient and family:Avoid fatty meals, stop smoking, exercise

STEP VI:Final Diagnosis: Acute cholecystitis

CCS- DYSFUNCTIONAL UTERINE BLEEDING

History of present illness:A 14 yr AAF with profuse vaginal bleeding comes to ER. She had her menarche 3 months ago and had irregular bleeding since then.

1. Note vital signs: BP, Pulse, Resp. Rate, Temp.

2. Check vitals to make sure pt is hemodynamically stable.

If patient unstable do Step I: see EMERGENT MANAGEMENT

For any female with abnormal vaginal bleeding you should check:

1. age of the patient

2. Family history of bleeding disorder

3. history of irregular cycles

4. evidence of bleeding problem on physical exam i.e. petechia

Differential diagnosis of vaginal bleeding:

1. dysfunctional uterine bleeding secondary to anovulation

2. endometrial neoplasia

3. endogenous source of estrogen i.e. granulosa cell tumor

4. uterine myomas with submucous myomas
5. hematologic disorders such as leukemia and idiopathic thrombocytopenia
6. endometritis and endometrial polyps

In this 14 year old female with h/o irregular cycles and no other signs on physical exam you should think of DUB secondary to anovulation which usually occurs in extremes of reproductive age, @ menarche and in peri-menopausal women.

Step I : Emergent management: A, B, C, D- if patient stable move to stepII

Step II : Physical Examination: Do focused PE: general, skin, chest/lung, heart, abd, genitalia, extremities

Step III : Diagnostic Investigations:

1. Pregnancy test
2. CBC- will show Hgb 7.0 – do cross and match if patient is hypotensive or symptomatic, Start IV access and consider NS
3. Chem 12 (glucose included), coagulation profile, TSH, ESR

Most likely in this case all test will be neg. except abnormal CBC.

Treatment: This patient is bleeding profusely and her Hgb is 7.0 so start estrogen IV 25mg q4h x3. And Ferrous sulfate 325 mg. Po tid

Bleeding should stop. Recheck CBC.

Step IV: Decision about changing patients location

1. Move patient to ward because her Hgb is low.
2. Repeat CBC following day and start OCPs
3. MVI one daily
4. Continue ferrous sulfate 325 po tid

If Pt's Hgb is stable, DC to home c office follow up in 1 week

Counsel Pt. on safe sex.

In office repeat CBC... if has improved follow up in 3 weeks. At that time you may D/C OCP and iron pills if you want to. (3 weeks of treatment is recommended with OCP). If patient desires you can continue OCP.

Final diagnosis: DYSFUNCTIONAL UTERINE BLEEDING

CCS- Alzheimer Dementia

History of present illness: 79 year old female comes to your office complaining of forgetfulness. The first and most important initial evaluation of patient with dementia is History and Physical examination. Important clues such as onset, duration, etc. will narrow your diagnosis and required investigating labs.

Note VS: BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

DDX: Alzheimer's dementia- Most common.

Vascular dementia- 2nd Most common.

Pick's disease –3rd most common.

Lewy body disease, Huntington's disease, Parkinson's disease

HIV- Related dementia

Head trauma related dementia

Step I : Emergent management: A, B, C, D- Not needed.

Step II : Physical Examination General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Extremities, Neuro/Psych.

Step III : Diagnostic Investigations: There are several diagnostic investigations for workup of dementia but H&P exam will narrow the list.

1. MMSE
2. CXR
3. EKG
4. CBC/Differential- To check for anemia.
5. UA, 6. Chem12- check for electrolyte abnormality
7. TSH- to rule out thyroid problem., 8. VDRL- To rule out syphilis
9. B12 level, 11. Urine Drug screening and heavy metals- guided by H&P
12. HIV test – guided by H&P
13. CT – guided by H&P, 14. LP- guided by H&P

Initial Treatment: Not needed.

Step IV: Decision about changing patients location

1. Some of the test you order may not be available right away, move patient home and schedule office appointment when all results are available.

2. Need to see patient initially weekly then monthly.

Treatment: 1. When diagnosis of Alzheimer is made by H&P and you've excluded other possible causes of dementia, start either Tacrine or aricept .

2. Add Vitamin E – it has shown that may slow progression of Alzheimer

3. Treat other complains that patient may have

Ectopic Pregnancy CCS

30 yrs old patient comes to the ER with Lower Abd Pain/Mass

Initial Orders :

.Pulse Ox

.IV Access

.Urine HCG

Interval History : Gen Exam, CVS, RS, Abd, EXT, Pelvic

Further Orders :

.CBC

.SMA7

Obtain Results of HCG-----> +

Further Orders :

Pelvic Ultrasound

Obtain Results of U/S-----> Ectopic Pregnancy

Further Orders :

.PT/PTT

.Type and Cross Match

.Blood Type and Rh Factor

.Patient's Consent

.Anesthesia Consult

.OB Consult-----> Case is Accepted for Surgery

.5 MINUTES WINDOW APPEARS

.FINAL DIAG : Ectopic Pregnancy

Final Message Appears : Thankyou FOR TAKING CARE OF THE PATIENT

Acute pancreatitis

Here are my tips..ACCORDING TO THE SOFTWARE

Location: Emergency

After the P/E..order:

FIRST....ARRANGE THE PATIENT FOR YOUR MANAGEMENT!!

Don't order iv Normal saline before the iv access

iv access

pulse oximetry

NPO

NG (select NGT, to staright drain...Recall you have to bowel decompression!)

Foley catheter

Urine output

complete bed rest

NOW THE PATIENT IS READY TO RECEIVE WHAT YOU WANT TOGIVE ..SO GO AHEAD!

IV Normal saline 0.9% (to support the circulation)..DON'T ORDER D5W% AS THE PATIENT MAY HAVE HYPERGLYCEMIA ..PAY ATTENTION TO THE TYPE OF THE IV FLUID!!

The patient in pain..so relieve the pain!!

IV percocet (OR IV meperidine)..Recall that morphine iv is a serious mistake..you know why

NO NEED TO GIVE ANTIBIOTICS UNLESS THE PATIENT HAS FEVER. IF SO, THE ABS OF CHOICE ARE IMPENEM/CILASTATIN..

iv Zantac..to prevent stress ulcer!!

iv promethzine or phenergan (anti-nausea!!)

BEFORE YOU MOVE THE CLOCK AND WITH YOUR INITIAL MANAGEMENT, ORDER THE LAB WORK:

CBC

SAM 12 (or CHEM 12)

SAM 12 includes the Liver function tests , electrolytes, renal function tests and glucose but not amylase and lipase!..so order them separately..

SERUM LIPASE

SERUM AMYLASE

crp(c-REACTIVE PROTIEN) AND ESR

THEN..MOVE THE CLOCK..

Now you stabilized the patient and it is the time of identifying the cause of the disease..so let's go to the imaging studies..What will you order??

THREE STUDIES USUALLY ORDERED TOGETHER:

Abdominal xray ..you may see sentinel bowel loop (dilated bowel loop near pancreas)..

Abdominal U/S..very important to see any gall bladder stones..

Abdominal CT scan...to detect the extent of pancreatic inflammation and development of seuelae of pancreatitis...

Move to the ward..

D/C NS

D/C NGT

but continue NPO, urine output!!

Order

D5W NSS

bed rest with bathroom privilages

Go to the interval/ follow up history and examination..to see how is your patient!!

order again..the amylase, lipase and BMP (or chem 7)

move the clock for one day..

D/c D5W

order diet, high liquid

advise

****ABSTEIN**** alcohol intake

smoking cessation

no illicit drugs

Move home..

Follow-up after one week

When he comes back, order bmp , lipase and amylase

before you exit the case, if the patient is female..order FOBT, mammography, pap smear as routine health tests ..make them after one year..

let's make ccs ridiculously simple

Remeber RANSON CRITERIA!!! IMPORTANT TOPIC

CCS..ECLAMPSIA...Real

Dos and Don'ts in this case:

(The Dos are in the software)

Location: Emergency

Order:

Airway suction

Intubate

Pulse oximetry

Oxygen

lateral decubitus position (available in the list..this is important to help imrove uterine blood flow and obstruction of the inferior vena cava by the gravid uterus)

NPO

NG tube

IV access

IV NS 0.9%(should be isotonic 0.9%..don't chose the hypotonic 0.45% or the hypertonic).

Foley cather

Urine output

BP monitoring
Cardiac monitoring
fingerstick glucose
dipstick urine protein
Fetal monitoring (Fetal heart sound monitoring)

Now, the immediate treatment:

IV magnesium sulphate, continuous

DON'T TRY TO ABORT THE SEIZURE BY ORDERING ANY OTHER
ANTICONVULSANT ..

Hydralazine IV, bolus

CBC
chem12
urine analysis
24-hour urine protein

The patient now should be stabilized..The patient will regain consciousness
D/C intubate
D/C NS

order
Cesarean section
Consult Obs. Reason (For further evaluation and termination of pregnancy by Cesarean
section).

So now prepare the patient for the operation..

Blood type and cross match
PT,PTT
Rhogam if the mother is Rh-ve.

Any additions????

That was great!BTW, should we include fundoscopy in the work up?

practice ccs like this : if u want to score Good and be safe in exam

A 57 yo male comes to OFFICE with complaints of fatigue, lethargy, appears pale and slow
patient drinks 4-5 glass of wine dialy at dinner. past hx is positive for smoking.

THIS IS JUST A SAMPLE NOT 100% ACCURATE (ONE CAN DO MINOR
CHANGES ACCORDING TO THIER WISH)

#1

FIRST PHYSICAL EXAM:

general APPEARANCE,heent, CHEST/RESP, ABDOMEN, EXTREMITIES, RECTAL

in EXAM RESULT U WILL SEE THIS : pale appreance, FOBT(fecal occult blood test)
negative.

rest of the exam is normal

#2 ORDERS:

CBC with diff

SMA12

UA

TSH (PT HAVe symptoms like hypothyrodism)

FOLIC ACID (patient appears anemic and hx of alchol use)

B12 (same reason as above)

CHEST XRAY

DISCHARGE PT HOME WITH F/U IN 2-3 DAYS

before dc .. console patient, reassure pt .

WHEN PATIENT WILL COME BACK TO u FOR F/U BY THAT TIME U WILL HAVE LAB RESULTS AVILABLE:

THESE ARE THE RESULTS:

CBC = HG 10 hct 32 MCV 108

folic is less then normal

B12 is normal

rest of the labs are fine

if this anemia was IRON deficiency and FOBT was positive in exam, U wud have done COLONOSCOPY definately but in this patient both findings are absent

now START TREATMENT :

prescribe Folic acid

prescribe multivitamins

advise avoid alcohol

advice some other health maintance stuff.

DC patient with 2-4 wks f/u

now when patient will come back he will say he feels better, improved energy, drinks less but continues to drink on and off

this visit

repeat CBC.

consider influnza vaccine

consider TD booster if he is due

advice safety, discuss advance directive etc etc

DC patient again with 4-6 wks f/u

MOST likely your case will end here

U will see 5 minute screen.

here u will recommend

AA groups if he is still drinking
some other advice,

avoid drinking and driving etc etc

FINAL screen

diagnosis = folic acid deficiency anemia secondary to alcohol abuse

THE end.

NOW THE WHOLE POINT OF THIS CCS presentation is ... PRACTICE CCS cases like this separately DONT mix this with ur MCQ's.....Best way is to have a clear plan of most often repeated CCS in your mind before u start.

CCS cases are more anxiety provoking while U are preparing for exam BUT in exam these are MUCH MUCH easy then u can imagine, if u Know the RITUAL of what to do. its like VIDEO games if u practice the game/scenario , u will know where the next bullet is gonna come from.

IF u do this... most ccs cases will run smooth

Thanks for the wonderful advice, I have a question, lets say his fobt is positive, now the next test is colonoscopy, now would you send him home and have him come back for colonoscopy and how do you prepare him for colonoscopy like bowel prep, golytely etc. thanks friend

Re: practice ccs like this : if u want to score Good and besafe in exam

for colonoscopy u will do the same, send pt home, let him come for follow up, and Type colonoscopy.

we dont have to prepare for CCS purposes

lets say u did colonoscopy , wich came positive, with cancer, u can still send the patient home with orders like this, consult GI / consult oncology/ consult surgery

(type this in consult request..57 yo male with abd pain, fobt +, anemia, biopsy + for adenocarcinoma of colon plz evaluate pt.)
they will say ,,, manage pt urself , if problem arises consult again.

dc pt home , f/u 1 wk, now admit pt to WARD... request surgery consult, then prepare for surgery like this:

IV access, iv fluids, NPO, type and cross match, PT/ PTT/ coagulation profile, FOley cath.

NOW order COLONECTOMY or COLON resection

case will definately END here

sorry i missed this

before surgery U wud like to do CT abdomen and chest xray for staging / MEtastasis

Hispanic lady of 35 yr coming to your office because of left chest pain. She has blues & says she fell.

CXR shows Fx of rib. suddenly she cries & says she has been abused by her husband.

Things I could do:

CBC, Pt, Ptt, CXR,

Tylenol

Counsel, safety plan

Counsel, educate patient!

Questions:

How to ask her to report the abuse herself?

How to ask her if the children are being abused?

How to ask her to put end to the abusive relation, that it would get worse if she doesn't leave, that the abuse is illegal, that it's not her fault.....

Please put your thoughts here. Exam in a week.

Thanks,

Sean

First you have to tx this pt with pain medication for her rib fx if her vital sign is normal

Work-up based on hx:

agree CBC, Pt, Ptt, CXR,

add to: EKG for R/O Myocardial contusion.

agree: Tylenol, may be need stronger than this, such as codeine...

Counsel, safety plan

Counsel, educate patient!

maybe age related health exam..

Questions:

(1). How to ask her to report the abuse herself?

ans.: you don't have to ask her to report spouse abuse, she make her decision whether she want to report or not. b'coz she is competent..

(2). How to ask her if the children are being abused?

Ans.: if she has a child(ren), type child protective consult..

(3). How to ask her to put end to the abusive relation, that it would get worse if she doesn't leave, that the abuse is illegal, that it's not her fault.....

ans.: you can ref (counsel) her to victim shelter and consult to social worker..

FEW complicated ccs cases recently appeared in exam:

we all know the case of child abuse but this is how it was presented

A 2 yr old kid brought to the er, he was found unconscious at home, mom said he was unconscious for 45 minutes, per mom he fell down the stairs and got a bruise on the head.

kid was very anxious in exam, mental status exam and neuro exam within normal range

phsyical exaination revealed brusies in arms , legs and abdomen,

this question can get easily confused with

3 scenerios?

1

off course everyone will think it may be INTRA cranial hemmorage with loss of consiousness,,

u do CT wich will come negative , so this is out fo the diffrential

2

now one wud think maybe he was some kind of bleeding disorder by looking at bruises all over the body

3

is child abuse,

in this case u do skeletal survey and u will find out patient has multiple fracture in different stages of healing.

von willebrand factors ,factor VIII all negative in lab

in this case u admit the patient to the floor, get social worker consult, inform mother by typing console patient(this is probably how u get mothers approval for admission) and in the end report child protective service by ordering a consult child protective services

case will end there

THIS CASE IS REAL TRICKY: i never heard of this before

47 yo immigrant (in usa since age 5), smoked cigarettes for 20 yrs in blast, works in shipyard, comes with cough, chills, hemoptysis, fatigue , wt loss x 6-8 months

everyone would think it is TB... as we all go to tb as soon as we SEE immigrant word.

labs chest xray cavitary lesion in rt.upper lobe
PPD is 12mm

sputum AFB (acid fast bacilli) negative

this case was confusing,,,

ordered CT chest same upper lobe cavitary lesion

this case was going on and on... finally i decided to do BRonchoscopy with biopsy

case ended there

I think now this case was ASBESTOSIS(mesothelioma)

one could get into these 3 d/d TB , lung cancer (secondary to smoking) and MEsothelioma(secondary to asbestos exposure)

THE THING about ccs cases is this,,,one got to be careful in a way...MOST cases are exactly the same as u see in this forum...but sometimes cases are different when u see them in exam,, the reason for this is..recallers JUST tells u the final diagnosis not the whole history for the cases.

AGAIN this is not to scare you guys,,,, i am going to repeat this again,,,, MOST CCS cases are exactly the same as u see in the forum except for few..(maybe this is thier new pool of ccs cases which are not posted so far by the exam takers)

this again brings us to the same point,,,,PLZ try to post ur cases as accurate one can post.

Out of nine cases i knew 6 cases immediately as soon i heard the chief complaint.. in 3 cases i had a hard time

cases are..

1)

a 9 month old kid with fever 104.5, irritable, and tachycardic with vomitting.

u did every lab possible(B culture, Lp, ua, urine culture etc etc) but nothing turned out to be possible

pt was given tylenol suppository, and broad spectrum antibiotics, admit the patient on floor.

one day later pt was CALM and fever came down to 102.0

then the case ended there

final diagnosis : fever of unkown origin or fever without focus: (this is my i cud be wrong in diagnosis)

2)

young black female with vaginal dc, sexually active, came to outpatient clinic, initial labs (vaginal smear revealed trichomoas budding hyphye etc etc)

given metronizadole dc home f/u in 4-5 days, she was cured
do appropraite counselling case will end there

3)

47 yo alcoholic with fatigue , pale , etc etc

do basic lab work u will see folic acid deficiency anemia,,,, (hb low, hct low, folic level low,)

started him on folic acid and multivitamins

pt felt better in few days

case ended there

4)

young female with nausea vomiting, lives with friend, comes to er with abdominal pain, nausea and vomiting... in HPI u will see she has insulin dependent diabetes x few yrs

as soon as read this HPI u know this is going to be a DKA
with some kind of infection

it was in ER.

u check blood glucose(finger stick) it was 487

urine ketone 4 +

ua is positive for nitrate and esterase (means pt has UTI)

make sure u do urine pregnancy test wich was negative

now u know the diagnosis DKA with uti

managed the patient as u do for DKA and treat UTI with antibiotic

like this roughly idea

iv acces

saline

insulin(regular)

repeat finger stick q 2-3 hours

repeat ketone later

ABG

add potassium if its low

antibiotic for uti (bactrim or anything u like)

next day patient is better, glucose came down to 300 something

THIS is just a idea,, not the exact management for DKA , plz follow ur own format

5)

a young lady with rt upper quadrant pain, nausea vomiting , chill, fever

us positive for gall stone and inflamed gall bladder

after ROUTINE drama (labs etc) u order surgery consult, surgeon will say continue pt management, u prepare patient for surgery

iv antibiotics for cholecystitis

NPO

foley cath

pt/ptt coag profile

compazine for nausea

input output

AFTER this

order cholecystectomy (laproscopic) case will end there

5)

polymyalgia rheumatica with temporal arteritis

this was a complicated case, as patient was depressed too,

labs positive for microcytic anemia

first thing first give PREDNISONE for temporal arthritis immediately

now manage the patient for anemia and depression

i was very confused about this case, i did many unnecessary labs and in fact i end up admitting the patient in hospital which i think was not necessary

I don't know exactly what is the management of this patient

CCS 1)... a 13 yo female came to office with mother with c/o increase amount of bleeding and weakness. . Periods are heavy from last two times. C/o back pain and taking some NSAID. Feeling weak and some pale.

H/o of father bleed excessively in past during dental extraction. Two brothers are ok.

My provisional Dx was VONWILLEBRAND DISEASE.

I will briefly tell what I did and where I found problem with soft wear of CCS.

1) CBC, Preg test, ua, sma7. pt, ptt

2) result shows anemia Hb 8, pt normal ptt slightly elevated and preg neg. PLT ok. I ordered BT , factor VIII, XI, von Willebrand factor, transfer to hospital. Repeat Cbc in 2 hours . IVF, type and cross

3) BT was 17, I started DDAVP cryoprecipitate, transfuse one RBPC.

4) Pt ok in next 6-8 hours bleeding reduced and feeling better.

5) could not DC pt but advised general counseling age appropriate and counseling to brothers, watch for bleeding in future, avoid ASP. etc

CCS 2)a 45 yo male. MVA. No seat belt, steering broken, no loss of consciousness pt breathing ok, pain on chest bruised, conscious.

My initial impressions was Cardiac tamponade or Aortic rupture.

1) Did ABC, IVF, oxygen, cervical spine precautions,
2) cbs, EKG, , sma7, pt , ptt, blood alcohol level, xray chest, aary extremities, spine, abd xray et, VS, m onitoring. Pain killer

3) chest xray sternal fracture, all ok, pt some SOB and distress,

4) Ct chest, called ortho,

%0 orths said no intervention needed, Ct showed fluid in pericardial space

5) stat pericardiocentesis, admit to ICU, monitoring,

6) pt got better. Next day much better

Again time is very short in CCS , I could not do repeat CT or DC pt . B/c when we orders so many thing its take time to see result and by the time case end.

7) Did some counseling, seat belt, age related and etc

CCS 3) 7 yo Black kid with arm pain, chest pain, fever, mild distress (office)

pt know case of sickle cell disease and on prophylactic penicillin and had pneumo vaccine.

1) cbc, sma7, ua, chest xray , ul abdomen, LFTs, bilirubin, ivf, oxygen, meperidine.

i did not order peripheral smear or Hb electrophoresis as knowing that its known case of SSD and we are going to see sickle cell.

My prov Dig was SICKLE CELL CRISIS AND ACUTE CHEST SYNDROME

2) Hb 7, last was 8. Transfer to hospital with continue oxygen , meperidine iv, ceftriaxone , IVF

pt better next day. Dc iv meperidine, started PO ,

3) advised Hydroxyurea and hydration.)-

Again it's hard to keep track with time of soft wear and to understand when to dc drug or dc patient.

4) did some counseling with drug adherence, hydration Dc ceftriaxone and stated PO, was already on PNC and vaccine.

CCS 4) A 35 yo hispanic female, s/p repair of femur fracture, next day nurse said

UOP 80 cc in last 8 hours. Pt ok but c/o some pain.

Other exam ok. pT IS ON SOME CEPHALOSPORIN(PROBABLY CEFOTAXIME AND SOME PAIN KILLER which was not apparent NSAID, was like phenylpyrazone ?? or Meperidine (dont remember exactly).

MY PROV DIAGNOSIS WAS ATN

1) did initial labs, Urine creatinine, urine eosinophil, urine sodium (did not do FeNa) .

2) there was granular cast and no leukocyte, so I ruled out interstitial nephritis and urine NA was 45. BUN 28 and creat 4.5

I was sure it's renal failure due to intrinsic problem and culprit is either cephalo or pain killer. I was not sure pain killer is NSAID or not so I d/c cephalosporin.

I am not sure I did right or wrong. I checked and did not see cephalo cause ATN, they cause nephritis.

3) continue with Furosemide and fluid and some basic counseling

Tried to counsel to avoid nephrotoxic but could not.

Final diagnosis I made ATN and Renal failure.

CCS5) 57 yo WM c/o mild cough, no other symptoms, no weight loss, h/o smoking but quit 3 years back, mild fever.

Chest exam with decreased BR on left base

My initial impression was b/w CAP or cancer

1) started with simple test CBC, sputum gram stain, UA, chest x-ray, etc,

CBC with WBC high, neut, chest xray with left lower consolidation and sputum with big amount of gram pos cocci.

I treat with Azithromycin, cough syrup and f/u in one week. also orders sputum c/s

2) did not get well in 10 week, c/o some blood in sputum. Did Ct chest and found mass at L lung.

3) request bronchoscope, consult oncologist and diagnose as Post obstructive Pneumonia and Lung cancer.

By the time case finished.

CCS6) A 72 yo with mild progressive SOB, hx of HTN and MI, on enalapril, office, PND and otherwise ok.

On exam some bilateral pitting edema and no JVP or other s/s of acute heart failure or pulmonary edema.

My provisional diagnosis was Congestive heart failure sec to HTN or IHD

1) CBC, SMA7, ccr, ekg, echocardiogram, lipid, etc as an outpatient.

2) results showed hypertrophy, axis dev, akinesis, EF was not given in report.

3) started on next visit in 3 days, HCTZ and Digoxin, counseling few things, low sodium, exercise, compliance with drug and f/u in 2 weeks.

4) pt was better, I checked SMA 7. (I did mistakes and forgot to see Dig level but there was no toxicity) pt was better.

4) f/u in 4w, and 3 months pt better.

Final Diag CHF (I did not add B blocker b/c was not sure about EF and he was already on ACE inhibitor. For got to add ASA too.

CCS7) a 45 yo IV drug abuser, fever, SOB, track marks

My initial impression was Acute bacterial endocarditis (like every one will do)

1. ivf, oxygen, orders initial test, Blood c/s, ccr, cbs, urine tox, hep panel, VDRL, etc

2) started on iv nafcillin and gentamicin.

3) admitted to ICU (I don't know floor was better, let me know)/with cardiac monitoring.

4) did not get temp down next day. Cont AB and send another set of Blood c/s. consent for HIV test. orders Echo, showed, vegetation on TV.

again its very hard to keep track of pt and what test to order here. its theoretically looks easy but soft wear is strange. May I did not do much practice, but I did practice. I could not see result of V Blood c/s in one week. Time was running.

So I changes AB to Vanco and Genta b/a pt was still having fever.

5) did some counseling, safe sex, druge ete etc, HIV test idi not came bacj but hep and vdrl was negetaive.

My Final Giag wae Av cute Bacerila Endocraditis, I did two important step like blood c/s and start AB before result which are life saving. I did know this is what USMLE want to see or to manage case entirely which was difficult for me.

4) in one week pt temp same

CCS8) 35 yo legal assistance female with non bloody diarrhea
weakness and pain in RLQ,

My initial impression was, CROHNS disease

1) did usual lab after IVF. LFT, CBS, PT, stool ova nd parasite, c/s, sma7.iron study, b12, FA

2) bi2 was low, iron very low anemic, mass on RLQ, abd series ok.

3) did barium (upper GI) some time we can do colconscoy or sigmiod, I choosed to do Barium

, admit to ward, NPO, TPN, B12, Iron,

4) barium neg , did colon scope showed ileum with cobble stone pattern no mucosa infalmed.

5) stated Masamine and predinisonone and all nutritional aids.

6) counseling few things, high fiber diet. and drug compliance and education.

could not f/u or DC . It was chronic problem , to DC pt and f/u . B/c management takes time and every case finished in 1-20 minutes or earlier

Finla Diag was Crohns disease

I mean I could not see how pt did and long term follow up . How much it is imporant in CCS. ??

CCS9) 45 yo female with discharge/ itching came to office other wise healthy

healthy and lst pap smear was 15 months back and normal

My initial Impression was Bacterila vaginosis

1) did preg test, ua, koh preo, wet mount smear, CBC

2) showed no huphes ar trichomonoas and lot of clue celle

3) treated with Meteo gel

4) Pt was happy in next 10 days.

5) Schedulled Pap smear and mamogram in next mont (to get rid of infaction.

General cousselling.

very nice solved 9 CCS cases , posted by a nice fellow

1. 55 yr old black woman with fatigue, weight gain, loss of lat third of eyebrow, obese and other nonspecific signs/sy presented to office (got a sense of hypothyroidism)----- did cbc, tsh(don't jump right away to whole thyroid function test as tsh is cost effective compared to whole thyroid pannel....if tsh comes abnormal then do whole thyroid pannel), comprehensive met pannel,ua and ana...tsh was high so ordered whole thyroid pannel which confirmed hypothyroidism.....so started on levothyroxine and scheduled wk f/u appt....now i also ordered ekg (h/o obesity and slight elevated bp) then i struggled about ordering about cxr but didn't instead preferred to order lipid profile(i was very ambivalent about ordering lipid profile in this guy from cost effectiveness/expense/unncessary vs necessary test etc) but surprisingly this guy had bad lipid profile so advised him low cholesterol,low fat, and low na(highbp) diet, exercise pgm, etc.....i also did stool guiac as part of yearly exam in this old pt but it was negative.....case ended on time and when 5min left screening warning came, i ordered repeat tsh (to make sure,it is going down)

2. 60 yr old african american pt with h/o arthritis and s/p chronic aspirin therapy presented to office with c/o fatigue(first thing came in mind was peptic ulcer dz vs gastritis).....ordered cbc, lyte plus, tsh,ua.....normocytic normochromic anemia with slightly low h/h.....did upper barium study came negative.....pt was feeling still same.....started on famotidine and advised to stop aspirin.....ordered couple days f/u and ordered gastroenterology consult.....still no improvement.....then finally did endoscopy.....and result was positive for erosive gastritis.....i continued famotidine(she was taking antacid with marginal relief), advised to quit aspirin, quit smoking, quit alcohol, started her on acetaminophen for pain and case ended.....(also advise this pt about routine self breast exam, exercise pgm, mammography, advanced directive etc.....Keep these age appropriate counselling in mind for every case ... cash extra few positive points.....always give pt opportunity to discuss about advanced directive....i this is new medicare and medicaid requirement and it is a law that hospital/clinic discuss advanced directive issue with all pt irrespective of their age)

3. 18 months infant presented with wheezing/coughing for six hours (knew right away foreign body aspiration).....started o2, iv access, cbc, bl culture, lytes, pulse ox, abg.....ordered cxr portable.....ordered pulmonology consult(u can order either pulmonology or cardiothoracic surgery consult for bronchoscopy).....message reads continue managing pt...no additional comments.....ordered endoscopy.....pt felt better.....transferred to ward.....ordered clindamycin first iv and then oral therapy(for postob pneumonia).....pt got better..message read peanut was revealed in bronchoscopy.....case ended on time.....(i forgot to order postbronchoscopy material for c/s as per std textbook instead started clindamycin empirically)

465 yr old man with unilateral headache/tenderness.....classic case of temporal arteritis.....ordered cbc, tsh, esr, lyte plus.....esr was 100.....started on prednisone.....ordered f/u appt and gave age appropriate counselling.....case ended

5. young woman brought in unconscious with bradycardia, hypotensive and pinpoint pupils classic case of narcotic od.....ordered oxygen, iv access and gave triple combo (thiamine, dextrose 50% and naloxone-all are iv bolus one time dose).....pt got awake. (Don't go first for physical exam in this case. Unconsciousness/unstable pt warrants urgent treatment).....i then did brief physical of 3min.....meanwhile i started her on normal saline, did cbcd, lyte plus, ekg 12 lead, cxr portable, pulseox, ekg monitoring, ua, urine drug screen, blood alcohol, blood aspirin and bl acetaminophen level, ordered gastric lavage(which revealed pills fragments).....started naloxone drip....transferred to icu..at one time i have to start here ng tube and intubation.....she eventually got better.....transferred her then to ward.....ordered psy consult, advice for relaxation technique to ease with stress(now can u believe what big mistake i did.....i had overdose protocol in my mind and i was writing all orders as it popped out of my mind.....there i ordered charcoal along with gastric lavage...this was big blunder.....but surprisingly pt got better.....i imagine i have her already on intubation.....even with this big mistake CASE ended peacefully)

6 young girl with fever, headache and generalized maculopapular rash of one day onset.....classical case of toxic shock syndrome.....ordered symptomatic rx...admitted and ordered cbcd, urine pregnancy, gono/chly vag culture, bl culture, cbcd, comp met pannel, uastarted her on iv oxacillin and then oral dicloxacillin.....pt got better (now in physical, it read "tempon removed").....still i go ahead and wrote remove tempon(computer has this order in storage).....did contraception, drug, alcohol, smoking, safety counselling being teenager. In the case i was confused about one thing i.e. culture and sensitivity.....i was not sure where to take specimen from? so i ordered bl culture, vaginal staphylococcal culture, and then tempon c/s (someone can help with this issue).....case ended appropriately

7. 55 yr old immigrant psychiatrist came in with classical sy of pul tb-----hemoptysis, wt loss, night sweats.....so did cbcd, ppd, cmp, ua, sputum afb smear, tb culture and pcr test.....(afb was negative.....pcr came positive after couple days).....pt was in office.....i wanted to order resp isolation but computer won't accept it and same token case was not appropriate for admission as she was young and independent and relatively healthy.....now i wanted to do sputumx3 (practical and theoretical approach) but computer won't accept it 2nd time).....ppd was 12mm, cxr revealed upper apical infiltrate/cavity.....started her on inh, pyridoxin, rifampin, etham....ordered f/u appt with f/u sputum study.....ordered inf/pneum vaccine, multivitamin/notify health dept.....i also did hiv counselling in this pt.....other things to check.....hep b surface antigen.....(lady was not drug addict so i didn't do rpr)

8 one case was 50 yr old guy with symptoms of dka, abdominal pain.....treated as dka but case kept dragging on and on.....

9. s/p mva, s/p internal fix of tibia # in 50 yr old guy in inpt setting.....nurse runs with c/o decreased urine output.....case of acute renal failure.....treated this case as mva.....don't assume that this pt has everything on place.....start with abc....o2, iv ring lac, foley cath, spine, cxr, pelvi xray.....ordered abg, ua, lyte plus.....significantly low

calcium, and k was 7.5.....ordered calcium chloride, ekg 12 lead and cont monitor.....case ended exactly at 14min.....diagnosis.....arf/hperkalemia/hypocalcemia.....

impt points:

1. first always decide pt is stable or unstable.....if unstable/unconscious start treatment first and then do physical.....
2. it takes 2-3 min to load pt.....i was scared becasue in all my pts, it was either 3rd or 4th min when i was able to wirte first order.....i think one has to be patience as computer takes little while to load info
3. always do age app counselling....
4. think twice before u write any order.....think about cost/necessity/futlity/whether it will change your mx (like always go first with tsh and then order whole pannel.....first do nonfasting cholesterol before going to fasting sample)

Do practice,practice and practice..... i have reviewed all ccs cases within last 4months from this site and practiced those couple times.....it really helped me lot in the exam.....Best thing would be discuss with friend. In my case, me and my friend used to discuss everyday 5 case on the phone. while talking to eachother through cell phone, we kept our computer open and practiced on those 5 std cases. we pretended case of asthma instead of pneumothorax and wrote all ordereds/treatment of astham and watched the capability of computer and how it comes up with words.....say for example while doing osteoporosis case before the test, when I ordered DEXA scan, computer doesn't recognize it but after several attempts, i was able to come up with right word"bone absorbtiometry" and computer picked up it right away so if u know this thing it will save time in real test.....thaks....

CCS..ECLAMPSIA...Real

Dos and Don'ts in this case:

(The Dos are in the software)..this case is not mentioned in the usmleworld.com..it is a real case though..

Location: Emergency

Order:

Airway suction
Intubate
Pulse oximetry
Oxygen

lateral decubitus position (available in the list..this is important to help improve uterine blood flow and obstruction of the inferior vena cava by the gravid uterus)

NPO

NG tube

IV access

IV NS 0.9%(should be isotonic 0.9%..don't choose the hypotonic 0.45% or the hypertonic).

Foley catheter

Urine output

BP monitoring

Cardiac monitoring

fingerstick glucose

dipstick urine protein

Fetal monitoring (Fetal heart sound monitoring)

Now, the immediate treatment:

IV magnesium sulphate, continuous

DON'T TRY TO ABORT THE SEIZURE BY ORDERING ANY OTHER ANTICONVULSANT ..

Hydralazine IV, bolus

CBC

chem12

urine analysis

24-hour urine protein

The patient now should be stabilized..The patient will regain consciousness

D/C intubate

D/C NS

order

Cesarean section

Consult Obs. Reason (For further evaluation and termination of pregnancy by Cesarean section).

So now prepare the patient for the operation..

Blood type and cross match

PT,PTT

Rhogam if the mother is Rh-ve.

HYPO

Location: Office..

Order:

CBC

THYORID PACKAGE 2 (available in the list)

Lipid profile

EKG, 12 lead (will show low voltage).

ECHO..may show effusion or cardiomegaly..

Lipid profile (may show hypercholesterolemia).

Thyroid scan..(to detect any nodules or infiltrative disease)..

You can also order FNA, thyroid..Fine needle aspiration is very useful in Hashimoto..

After you receive the results of the above tests, order:

thyroid, anutoantibodies...recall that hashimotos is an autoimmune disease in which the antibodies destroy the tiisue causing the hypothyroidism..

Now the tx will be levo-thyroxine ORAL ..available in the list..

Advise patient (medication compliance)..

advise, diet LOW CHOLESTEROL..

Schedule follow-up after two weeks..

When the patient comes up, measure TSH level (should be lower) and thyroxine serum level (available in the list)..

lung cancer

My approach is just for the SOFTWARE!

Scenario: weight loss/hemoptysis

Location: OFFICE

Order:

CBC
CXR
EKG, 12 lead (if there is chest pain!!)
Spirometry (if there is SOB)
PT,PTT,BT
BMP

Results: The CXR may show solitary pulmonary nodule...

Move to the WARD...

IF THE CHEST XRAY SHOWS PLEURAL EFFUSION< DON'T FORGET TO ORDER PLEURAL TAP....ALWAYS ORDER THORACENTESIS IN PLEURAL EFFUSION AND THEN ORDER

complete pleural fluid analysis

PLEURAL FLUID, LDH

PLEURAL FLUID, cytology

PLEURAL FLUID, glucose

Pleural fluid, protein

Pleural fluid, gram stain

Pleural fluid, C&S

BY THE WAY, YOU CAN GUESS THE TYPE OF THE CANCER FROM ITS LOCATION..IF CENTRAL. SMALL CELL CA OR SQUAMOUS BRONCHOGENIC CA...IF PERIPHERAL, ADENOCARCINOMA. OR LARGE CELL CA. !!!

so order CT, SPIRAL, thoracic..SPIRAL IS MUCH MORE SENSITIVE IN LUNG CANCERS..

Also order:

Abdominal CT..(to detect any metastasis..if any!)

*****BONE SCAN*****

BROCHOSCOPY...When you type bronchoscopy, the software will take you to the consult ..

Or you can order BIOPSY..then select BIOPSY, TRANSBRONCHIAL...ESPECIALLY IF YOU SEE THE MASS CENTRAL ON THE XRAY AND CAT SCAN..

IF IT IS PERIPHERAL, TRANSBRONCHIAL BIOPSY WILL BE DIFFICULT..

SO SELECT, BIOPSY..transthoracic..(this is important for the mcq)..it doesn't matter here because whatever route of the bx you choose, the software will take you to the consult..

select, consult, thoracic surgery

Reason..For further evaluation,lung biopsy and ..
possible lobectomy..

SIGN YOU RECEIVE: patient is scheduled for surgery..continue in the management..

Consult..oncology
consult..radiotherapy
So prepare the patient for surgery

Blood match and type
*****pulmonary function test..
*****ABG
very important for preoperative fitness evaluation....

Consult..ONCOLOGY

Reason (for possible adjuvant chemotherapy/radiotherapy)
DON'T FORGET:.....

ADVANCE DIRECTIVE
ADVISE PATIENT, LIVING WILL!!!!!!!

ADVISE..
*****STOP SMOKING*****
no alcohol

Ectopic Pregnancy CCS

30 yrs old patient comes to the ER with Lower Abd Pain/Mass

Initial Orders :

.Pulse Ox

.IV Access

.Urine HCG

Interval History :Gen Exam,CVS,RS,Abd,EXT,Pelvic

Further Orders :

.CBC

.SMA7

Obtain Results of HCG-----> +

Further Orders :

Pelvic Ultrasound

Obtain Results of U/S-----> Ectopic Pregnancy

Further Orders :

.PT/PTT

.Type and Cross Match

.Blood Type and Rh Factor

.Patient's Consent

.Anesthesia Consult

.OB Consult-----> Case is Accepted for Surgery

.5 MINUTES WINDOW APPEARS

.FINAL DIAG : Ectopic Pregnancy

Final Message Appears : Thankyou FOR TAKING CARE OF THE PATIENT

Acute pancreatitis

Here are my tips..ACCORDING TO THE SOFTWARE

Location: Emergency

After the P/E..order:

FIRST....ARRANGE THE PATIENT FOR YOUR MANAGEMENT!!

Don't order iv Normal saline before the iv access

iv access

pulse oximetry

NPO

NG (select NGT, to staright drain...Recall you have to bowel decompression!)

Foley catheter

Urine output

complete bed rest

NOW THE PATIENT IS READY TO RECEIVE WHAT YOU WANT TOGIVE ..SO GO AHEAD!

IV Normal saline 0.9% (to support the circulation)..DON'T ORDER D5W% AS THE PATIENT MAY HAVE HYPERGLYCEMIA ..PAY ATTENTION TO THE TYPE OF THE IV FLUID!!

The patient in pain..so relieve the pain!!

IV percocet (OR IV meperidine)..Recall that morphine iv is a serious mistake..you know why

NO NEED TO GIVE ANTIBIOTICS UNLESS THE PATIENT HAS FEVER. IF SO, THE ABS OF CHOICE ARE IMPENEM/CILASTATIN..

iv Zantac..to prevent stress ulcer!!

iv promethazine or phenergan (anti-nausea!!)

BEFORE YOU MOVE THE CLOCK AND WITH YOUR INITIAL MANAGEMENT, ORDER THE LAB WORK:

CBC

SAM 12 (or CHEM 12)

SAM 12 incluses the Liver function tests , electrolytes, renal function tests and glucose but not amylase and lipase!..so order them separately..

SERUM LIPASE

SERUM AMYLASE

crp(c-REACTIVE PROTIEN) AND ESR

THEN..MOVE THE CLOCK..

Now you stabilized the patient and it is the time of identifying the cause of the disease..so let's go to the imaging studies..What will you order??

THREE STUDIES USUALLY ORDERED TOGETHER:

Abdominal xray ..you may see sentinel bowel loop (dilated bowel loop near pancreas)..

Abdominal U/S..very important to see any gall bladder stones..

Abdominal CT scan...to detect the extent of pancreatic inflammation and development of sequelae of pancreatitis...

Move to the ward..

D/C NS

D/C NGT

but continue NPO, urine output!!

Order

D5W NSS

bed rest with bathroom privileges

Go to the interval/ follow up history and examination..to see how is your patient!!

order again..the amylase, lipase and BMP (or chem 7)

move the clock for one day..

D/c D5W

order diet, high liquid

advise

****ABSTEIN**** alcohol intake

smoking cessation

no illicit drugs

Move home..

Follow-up after one week

When he comes back, order bmp , lipase and amylase

before you exit the case, if the patient is female..order FOBT, mammography, pap smear as routine health tests ..make them after one year..

let's make ccs ridiculously simple

CCS-Trichomonas vaginitis (Office)

24 y/o female complaining vaginal discharge and itching.

Labs:

CBC

Chem7

wet mount (saline and KOH) test to identify the organism

DX of trichomonas: pruritis, fishy odor, gray or yellow-green discharge, pH>4.5.

Treatment:

metronidazole 2gm x1 and treat partner.

At discharge consult pt. For safe sex.

CCS- Colon cancer

History of present illness:

60 year old male presenting to office for regular checkup.

VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

Step I : Emergent management:

A, B, C, D-Not needed

Step II : Physical Examination

Complete- General appearance, Skin, Lymph Nodes, HEENT/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III : Diagnostic Investigations:

1. CBC

2. UA

3. Chem-12

4. Lipid profile

5. Because of his age he needs Guaiac stool, If positive followed by colonoscopy. result will show evidence of colon cancer.

6. Liver function tests, Chest x-ray to look for metastatic disease.

Step IV: Decision about changing patient's location

1. After initial workup admit patient for elective surgery.

2. Surgery consult. Get type and cross, CBC, Chem 12, EKG, CXR, PT, PTT, LFT, inform consent, NPO, and CEA level prior to surgery.

STEP V: Educate patient and family:

After surgery patient should be evaluated every 3-6 months for 3-5 yrs with history, physical examination, fecal occult blood testing, liver function tests, and CEA determinations.

Clonoscopy is performed within 6-12 months after operation to look for evidence of recurrence and then every 3-5 years.

Step VI: Final Diagnosis:

Colon Cancer

CCS-Erosive Gastritis

History of present illness:

55 yr old African American pt with history of Arthritis/chronic aspirin therapy presented to office with c/o fatigue

VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)

Allergy: NKA

Step I: Emergent management:

A, B, C, D-Not needed

Step II: Physical Examination

Complete- General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III: Diagnostic Investigations:

1. CBC (Normocytic Normochromic Anemia)
2. TSH
3. Chem-12
4. Occult blood test stool (+++): because of his age he needs to go directly to:
5. Colonoscopy (-) followed by endoscopy (++) for gastric ulcer, no evidence of malignancy)
6. DC ASA
7. Start Acetaminophen, Zantac
8. from the counseling list: Quit smoking
9. from the counseling list Quit alcohol
10. Advanced directive

Step IV: Decision about changing patient's location

Home with 2 weeks follow up
Pt comes feeling better
Do Interval history and physical exam
Repeat CBC only

STEP V: Educate patient and family: and case will end here

Step VI: Final Diagnosis:
Erosive Gastritis

Sickle-cell crisis(office)

HPI
6 Year old AAM was brought to your office because of pain he has a history of sickle cell disease.

PE:
Complete PE

labs:
CBC
Chem 7
Type and cross

Treatment:
pulse ox
o2
Iv Fluid
morphine
exchange blood transfusion- if patient doesn't improve or Hgb is low.
folic acid
immunization: H.influenzae B and pneumococcal vaccines
Aminocaproic acid for hematuria
If recurrent CVA, chronic transfusion program

Education
Counsel

HPI
25 Year old WF c/o lower abd pain.

PE:

Pregnancy test

CBC

Chem7

Endocervical gram stain-

for gram-negative intracellular diplococci

Endocervical culture-

for gonorrhea

Endocervical culture or antigen test-

for chlamydia

TREATMENT:

Outpatient, normally

Hospitalization recommended in the following situations:

Uncertain diagnosis

Surgical emergencies cannot be excluded, e.g., appendicitis

Suspected pelvic abscess

Pregnancy

Adolescent patient with uncertain compliance with therapy

Severe illness

Cannot tolerate outpatient regimen

Failed to respond to outpatient therapy

Clinical follow-up within 72 hours of starting antibiotics cannot be arranged

HIV-infected

GENERAL MEASURES

Avoidance of sex until treatment is completed

Insure that sex partners are referred for appropriate evaluation and treatment. Partners should be treated, irrespective of evaluation, with regimens effective against chlamydia and gonorrhea.

SURGICAL MEASURES

Reserved for failures of medical treatment and for suspected ruptured adnexal abscess with resulting acute surgical abdomen

Inpatient treatment;

Cefoxitin IV

cefotetan IV

(or other cephalosporins such as ceftizoxime, cefotaxime, and ceftriaxone) plus doxycycline orally or IV

CCS-PID

Therapy for 24 hours after clinical improvement and doxycycline continued after discharge for a total of 10-14 days

Clindamycin plus gentamicin loading dose IV or IM

Therapy for 24 hours after clinical improvement with doxycycline after discharge as above

Outpatient treatment

ceftriaxone plus doxycycline orally for 10-14 days

Ofloxacin orally for 14 days plus either clindamycin orally or metronidazole

PATIENT MONITORING

Close observation of clinical status, in particular for fever, symptoms, level of peritonitis, white cell count

safe sex practices education-

particularly for those who have had an episode of PID

CCS- chron's disease

HPI

28 y/o female comes to office c/o diarrhea for several days.

PE:

Complete-

Labs:

CBC- check for leukocytosis

Chem7

Guiac - positive for blood

stool culture- WNL

stool for ova and parasite- WNL

Colonoscopy- biopsy- inflammatory process consistent with chron's disease

Treatment:

mesalamine

antidiarrheal

reevaluate patient in couple days- patient diarrhea has improved. Patient is feeling better.

see patient in 2 weeks

diagnosis:

chron's disease

-Prednisolone 20-40mg/day & Azathioprine in acute disease treatment

mesalamine for remissions

Am I right?

CS- APKD

HPI

32 y/o male for routine check up.

PE:

complete

LABORATORY

CBC- Hematocrit - elevated in 5% of cases

Urinalysis - may have hematuria and mild proteinuria

Chem 7- Serum creatinine may be elevated

Kidney U/S - stones usually calcium oxalate

IMAGING

Ultrasonography:

> 5 cysts in the renal cortex or medulla of each kidney, in children, 2 or more cysts in either kidney

CT scan-

more sensitive

85% of patients can be detected by age 25

TREATMENT:

Outpatient-

except for complicating emergencies (infected cysts require 2 weeks IV antibiotics then long-term oral antibiotics)

GENERAL MEASURES

bed rest and analgesics for Pain

ACTIVITY Avoid contact activities that may damage enlarged organs.

DIET Low protein diet may retard progression of renal disease.

PATIENT EDUCATION

Genetic counseling is critical

Avoidance of nephrotoxic drugs

Treatment:

No drug therapy available for polycystic kidney disease

Hypertension - ACE inhibitors; avoid diuretics (possible adverse effects with cyst formation)

CCS-Gastric Cancer

67 y o lady with HX of fatigue (Dyspeptic symptoms with weight loss)

VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)

Allergy: NKA

Step I: Emergent management:

A, B, C, D-Not needed

Step II: Physical Examination

Complete- General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro

Step III: Diagnostic Investigations:

1. CBC (Iron Deficiency Anemia)

2. Peripheral Smear

3. RI

4. TSH

5. Chem-7

4. Occult blood test stool (+++): because of her age she needs to go directly to:

Step IV: Decision about changing patient's location

Transfer Patient to Medical Ward (Colonoscopy is a hospital procedure)

1. Emergent Lower colonoscopy and work based on the result (here will be -)

2. Emergent upper endoscopy with cytologic brushing and biopsies (adeno cell Ca)

3. LFT (metastasis)

4. Abdominal CT for identifying distant metastases.

5. Pre op workup such as blood type/cross match, CXR, EKG, PT, PTT, BT, start iron, Zantac.

6. Consult Surgery/Oncology/: Message surgery will be available shortly
DO interval/brief physical exam

STEP V: Provide counseling from the list (Pt/family/advance directive)

Case will end here

Step VI: Final Diagnosis:

Gastric Cancer

CCS- Active Tuberculosis

TB (Sudan immigrant Case): office

History of present illness:

55 yr old immigrant psychiatrist came in with classical symptoms of pulmonary TB

Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

Step I : Emergent management:

A, B, C, D- Not needed

Step II : Complete Physical Examination

Step III : Diagnostic Investigations: Order the following:

1. CBC
2. PPD
3. Chem. 12, LFT
4. UA
5. Sputum smears AFB
6. Sputum TB culture and PCR test(result will be ready by PCR within 24 hrs)

Now get the results of (AFB was negative. PCR came positive after couple days).

Order CXR and the result was (upper apical infiltrate/cavity).

Now you need to decide to admit or treat as an outpatient (remember hospitalization for the initial therapy of TB is not necessary in most patients)

Step IV: Decision about changing patients' location Treatment plan:

1. Notify the health dept.
2. Start treatment with 4 drug regimen: INH, Rifampin, Pyrazinamide, and either Ethambutol or Streptomycin
3. Weekly sputum smear and cultures and then monthly once they test negative.
4. Ordered f/u appt with f/u sputum study.
5. influenza/pneumonia vaccine, multivitamin
6. HIV Test in all pts with TB

Step V: Educate patient and family: Counseling and Education.

Step VI: Final Diagnosis: Active Tuberculosis

CCS- AMI

History of present illness:

A 45 yrs old patient brought to the e.r. with excruciating stabbing pain on his chest and inner arm for 20 min. the pt. has no history of previous attack but is a hypertensive candidate with BP 190/ 96 when last taken. pt. is conscious but looks anxious. vital sign; temp-97, pulse-86/min, resp. rate-33/min,

Step I : Emergent management:

A, B, C, D- O2, IV access,

Step II : Physical Examination

Focus PE Heent/Neck, Chest/Lungs, Heart/Cv, Abdomen, Extremities

Step III : Diagnostic Investigations:

EKG, CXR, CK-mb, Troponin-I, CBC, Chem –7, continues cardiac monitoring

Treatment:

1. NTG 0.4mg sl
2. Aspirin
3. Morphine if patient is in pain
4. ACEI (ramipril)
5. Depending on time since onset consider t-PA if not contraindicated or cardiac cat.
6. Consider nitroglycerin drip. Other antihypertensive you may consider is labetalol or nifedipine (more severe cases).

Step IV: Decision about changing patients location

1. Admit the patient to CCU, if patient is symptomatic send to ward.
2. repeat cardiac markers
3. discountinue cardiac monitor after 24 hours if patient is stable
4. When patient is stable consider submaximal exercise test
5. All patient with MI should go home on B-blockers
6. check lipid profile
7. consult on healthy life style prior to discharge
8. make appointment to see him in about a week

STEP V: Educate patient family.

console patient, stop smoking, diet, exercise.

STEP VI: Final Diagnosis.

AMI

CCS- Acute cholecystitis

History of present illness:

Most likely a 42 year old female was having lunch developed abd pain with nausea and vomiting.

Note: BP, P, RR, HR, quality of pain, duration of pain.

DDX-

1. Acute pancreatitis
2. Ulcer
3. Diverticulitis
4. Pneumonia
5. hepatic abscess
6. hepatic tumors
7. irritable bowel disease
8. Non- ulcer dyspepsia
9. Pancreatitis

Step I : Emergent management:

Most likely not needed.

Step II : Physical Examination

General appearance, Heent/Neck, skin, chest/lung, heart/CV , Abdomen

Step III : Diagnostic Investigations:

1. CBC w/diff. – (leukocytosis 12000- 15000) ,Chem12, amylase, lipase,LFT (Ast, Alt, and GGt will be slightly elevated), fasting Lipid profile.
2. Upright abdominal X-Ray (15% calcium stones)
3. USG if questionable do Tc-99m-IDA (HIDA)- if USG shows no stone and HIDA is positive consider Acalculous cholecystitis.
4. pregnancy test especially if result not clear or medication is to be given

Treatment:

For patient who are sick enough to be admitted.

1. NPO
2. IV Fluid
3. demerol for pain
4. Nasogastric suction

Step IV: Decision about changing patients location

1. If mild can be treated outpatient with low fat diet and actigal
2. Admit If pain is >6 hour and showing toxicity, Jaundice, rigors, or requiring narcotics for pain.
3. Admit to ward
4. surgical consult- if no perforation or CBD obstruction
5. If surgery is to be done prepare with CBC, chem7, CXR, PT, PTT, cross and match, EKG
6. Antibiotics cefotetan, or clindomycin and gentamicin
7. when patient stabilize discharge home

STEP V: Educate patient and family:

Avoid fatty meals, stop smoking, exercise

STEP VI: Final Diagnosis.

Acute cholecystitis

CCS- DKA vs Hyperosmolar state

History of present illness:

25 yo woman, with abdominal discomfort and confusion (blood sugar over 600 mg/dL).

Note vital signs: BP, Pulse, Resp. Rate, Temp.

Check vitals to make sure pt is hemodynamically stable. Is there History of diabetes? (new onset ?)

DDX:

DKA vs hyperosmolar state

Step I : Emergent management:

A, B, C, D- IV access followed by 0.9 NS (pt. with hyperosmolar and hypotension from hypovolemia use NS otherwise ½ NS is preferred because of marked hyperosmolar state) , IV insulin

Step II : Physical Examination

General appearance, skin, HEENT/ Neck, Chest/Lung, Heart/ CV Abdomen, Neuro/Psych

Step III : Diagnostic Investigations:

1. CBC
2. Chem 12
3. FSBS
4. ABG
5. UA
6. ABG
7. serum ketone
8. Amylase and Lipase (usually positive in abd. Cause)
9. serum osmolality
10. EKG
11. Hgb A1c

Treatment:

1. Continue IV hydration with NS until blood sugar is around 250 mg% then consider D5 ½ NS. Change insulin to subq instead of IV.
2. Monitor potassium , phosphate and Mag. And replace.

Step IV: Decision about changing patients location

1. Patient need to admitted to ICU initially then to ward when stable
2. After patient is stabilized investigate the cause if is still unclear.
3. Discharge home with follow up visit

Step V: Educate patient and family:

Educate patient on diabetic diet, exercise , signs of hypoglycemia

Final Diagnosis:

Key points in differentiation between DKA and Hyperosmolar is as follow
DKA:

1. hyperglycemia >250 Mg/dl
2. Acidosis with blood PH< 7.3
3. Serum bicarbonate <15 meq/dl
4. serum positive for ketones

Hyperglycemic hyperosmolar state:

1. Hyperglycemia >600 Mg/dl
2. Serum osmolality >310 mosm/kg
3. No acidosis; blood PH above 7.3
4. Serum bicarbonate >15 meq/L
5. Normal anion gap (<14 meq/L).

CCS- DYSFUNCTIONAL UTERINE BLEEDING

History of present illness:

A 14 yr AAF girl with profuse vaginal bleeding comes to ER. She had her menarche 3 months ago and had irregular bleeding since then.

1. Note vital signs: BP, Pulse, Resp. Rate, Temp.
2. Check vitals to make sure pt is hemodynamically stable. If patient unstable do step I.

For any female with abnormal vaginal bleeding you should check:

1. age of the patient
2. Family history of bleeding disorder
3. history of irregular cycles
4. evidence of bleeding problem on physical exam i.e. petechia

Differential diagnosis of vaginal bleeding

1. dysfunctional uterine bleeding secondary to anovulation
2. endometrial neoplasia
3. endogenous source of estrogen i.e. granulosa cell tumor
4. uterine myomas with submucous myomas
5. hematologic disorders such as leukemia and idiopathic thrombocytopenia
6. endometritis and endometrial polyps

In this 14 year old female with h/o irregular cycles and no other signs on physical exam you should think of DUB secondary to anovulation which usually occurs in extremes of reproductive age, menarch and perimenopausal women.

Step I : Emergent management:

A, B, C, D- if patient stable move to stepII

Step II : Physical Examination

Do a focus PE: general, skin, chest/lung, heart, abd, genitalia, extremities

Step III : Diagnostic Investigations:

1. Pregnancy test
 2. CBC- will show Hgb 7.0 – do cross and match if patient is hypotensive or symptomatic start IV access and consider NS
 3. Chem 12 (glucose included), coagulation profile, TSH, ESR
- Most likely in this case all test will be neg. except abnormal CBC.

Treatment:

This patient is bleeding profusely and her Hgb is 7.0 so start estrogen IV 25mg q4h x3.
And Ferrous sulfate 325 mg. Po tid
Bleeding should stop. Recheck CBC.

Step IV: Decision about changing patients location

1. Move patient to ward because her Hgb is low.
2. Repeat CBC following day and start OCP
3. MVI one daily
4. Continue ferrous sulfate 325 po tid

If patients Hgb is stable discharge patient home with office follow up in one week
Consult on safe sex.

In office repeat CBC if has improved follow up in 3 weeks at that time you may D/C
OCP and iron pills if you want to. (3 weeks of treatment is recommended with OCP). If
patient desires you can continue OCP.

Final diagnosis:

DYSFUNCTIONAL UTERINE BLEEDING

CCS- Pneumocystis Carinii Pneumonia with Candida Vaginitis.

History of present illness:

40 year old homosexual female, cough and fever, vaginal itching .

Note where the patient is on presentation, if she is in your office after initial work up,
patient should be transferred to Ward or ICU (depending on presentation but most likely
to ward). Unless the symptom are mild in that case treat patient in the office.

VITAL SIGNS- will help you to determine if patient is stable or unstable. BP (N= 90-
140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C,
98.6F)

Allergy: NKA

DDX-

Pneumocystis pneumonia- Top of your list because of risk factor and OI at presentation.
Cytomegalovirus

Kaposi Sarcoma
Legionellosis
Lymphocytic Interstitial Pneumonia
Mycoplasma Infections
Nocardiosis
Bacterial Pneumonia
Fungal Pneumonia
Viral Pneumonia
Pulmonary Embolism
Tuberculosis

Step I : Emergent management:

A, B, C, D- depending on presentation and assessment of O2 sat. if O2 sat is low. Start with one liter O2 and get IV access.

Step II : Physical Examination

Any suspect HIV/AIDS patient should have a complete physical exam.

General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III : Diagnostic Investigations:

1. O2 sat.- Pulse oximetry is obtained as part of the initial workup
2. ABG- with signs of respiratory distress.(hypoxemia)
3. LDH- Levels are noted to reflect disease progression. High levels during treatment indicate therapy failure and worse prognosis.
4. CBC/D-
5. Chem-12
6. CXR- The classic finding is diffuse central (perihilar) alveolar or interstitial infiltrates. Normal CXR is found in 5-10% of cases.
7. Sputum- by-sputum induction for Wright-Giemsa stain or direct fluorescent antibody (DFA) for Pneumocystis if PCP is strongly suspected. If negative and PCP suspicion is high next step is bronchoalveolar lavage.
8. HIV test- when you order a test like HIV that requires patient consent, it will tell you that patient consented to the test and result will be available in 7 days.
9. CD4 count
10. PCR assay
11. Saline or KOH Vaginal secretion (wet mount).
12. LFTs
13. VDRL, Toxoplasma IGG, and hepatitis B and C serologies.
14. Cervical papanicolaou Smear
15. TB skin test.

Treatment:

1. IV fluid –NS (In moderate- severe cases).

2. If suspicion is high for PCP start treatment with Bactrim-DS po bid for 14-21 days. If patient is hypoxic, start with Bactrim IV.
3. Report positive result to Department of Health and Human services.

Step IV: Decision about changing patients location

1. Mild-to-moderate disease refers to patients with milder symptoms and a nontoxic clinical appearance. They generally are not hypoxic and may even have a normal CXR. Outpatient oral therapy can be considered for these patients.
2. Moderate-to-severe disease describes patients with severe respiratory distress, hypoxemia, and, often, a markedly abnormal CXR. Inpatient management with rapid diagnosis and treatment is essential.
3. Admit patient to ward for moderate to severe disease. (ICU if patient unstable). Mild cases should be managed outpatient.
4. Discontinue IV fluid if patient is taking po and is not dehydrated.
5. Continue Bactrim -
6. Treat Vaginal candidiasis with antifungal such as nystatin, clotrimazole, miconazole vaginally.
7. When diagnosis of AIDS is established start Antiviral therapy with:
 - A. 2 NRTIs + 1 or 2 PIs.
 - B. 2 NRTIs + an NNRTI
8. Vaccines: Influenza, Hepatitis A and B, Pneumococcal vaccine.
9. when patient is stabilized cancel IV fluid, move patient to home with follow-up in your office in 5-7 days.
10. Continue Bactrim and antifungal- discontinue antifungal when patient returns for follow –up unless symptoms still persist in that case consider changing antifungal.

Step V: Educate patient and family:

1. Educate patient on safe sex.
2. Educate patient on Medication compliance.
3. Console patient on HIV support group. When you request this option it tells you arrangements for follow-up has been made.

Step VI: Final Diagnosis:

Pneumocystis Carinii Pneumonia (PCP) with Candida Vaginitis.

Cystic fibrosis in 5yo child

O2 mask

Labs:

sweating test($Cl > 60 \text{ mEq/dl}$ dgn)

CXR

Pulmonary function test

ABG's

Sputum culture & sensitivities of cultured organisms

Tx:

Ab-iv ceftriaxone+gentamycine for pulm.infections

Albuterol inh

Chest physiotherapy:

postural drainage+percussion

breathing exercise

vigorous coughing

exercise program

Recombinant human deoxyribonuclease-jet nebuliser

Case4

Child living in an old house coming to regular checkup

CBC

Blood lead($> 25 \text{ micro/dl}$)

Free erythrocyte protoporphyrin($> 35 \text{ micro/dl}$)

urinalysis

knee&wrist Rx->increased density in metaphyseal plate long bones=lead lines

Tx

report to local health board

remove child from environment

Tx:

EDTA+dimercaprol for 5 days

penicillamine for 3-6 months

Child abuse

Admit the child in ward room

labs:

CBC

PT

PTT

bleeding time

ophthalmologic consult for retinal hemorrhages

CXR

skeletal RX

social worker

report to local authorities

spousal abuse

Aside for specific investigations&tx suggested by P/E reffer the patient to victim assistance service

eldery abuse

as in above cases)investigations and tx suggested by P/E,than refferal to elder protective services

N.B.whenever you are uncertain about were you should reffer the patient type:"reffer the patient" and choose from the list.]]

Uncomplicated MI approach

Here is my management for an uncomplicated MI:

So->presentation of chest pain suggestive for MI:

P/E-chest,abdomen,extremities=3 minutes

1)Aspirin chewing

2)O2 mask

3)IV line

4)ECG 12 lead

5)ECG monitoring

6)vitals monitoring

7)cardiac enzymes(CPK-MB,cTnT)

pulseoxymetry monitoring

9)Morphine sulphate i.v.

other Labs:CBC with diff

ABG's

Lytes

Chem 7

PT&aPTT

blood type &crossmatching

LFT's

Urinalysis,creatinine,BUN

glucose serum

TSH

imagistic:

CXR

abd plain films

cardiac ECHO

if no inferior MI/no hypotension->nitroglycerin iv

Look for CI to thrombolysis->if no CI->heparin iv

then streptokinase bolus

if CI to thrombolysis->stenting PTCA call interventional cardio

the patient is stabilised->transfer in ICU

d/c oxygen

adm.methoprolol iv

continue monitoring for 3 days

Diet liquid

Psyllium cysapride to prevent constipation

2'nd day

Tc scintigram-evaluation of affected miocardum

complete P/E

3'rd day continue measures- early ambulation (go to the bathroom)

4'th day non-stress submaximal effort test
discontinuation of monitoring,
transfer in ward room
5'th day D/c of iv medication
propranolol p.o.(chose because of lowcost)
cord-pulmon examination
look for patient immunisation status
if no influenza&pneumo
advise patient to stop smoking &drinking
6'th day begin solid alimentation
7'th day again submaximal treadmill test
discharge
Final recomandations:
diet low salt low cholesterol
continue aspirin indefintite
come back to control in one month
rest at home for 3 months

Chronic cardiac failure

admit patient
1)search for cause->most freq Hypertension&CAD
2)classification acording NYHA
monitor:weight,vitals,fluid intake,urinary output
nonpharmacologic measures:
restriction of physical activity
weight loss
dietary Na&water restriction
O2 mask for dyspneea
pharma:
ACEI(enalapril)
nitrates
hydralazine->in combination with nitrates improve survival
Digoxin when no ci

diuretics(HCTZ)

Special considerations:

HF+MS->avoid phys.exercise

Lasix

heparin followed by long term warfarin

treat AF with cardioversion if unstable or with digoxin if stable

prphylaxis for inf. endocarditis

HF+AS as in MS but diuretics with caution.Avoid nitrates.

HF+chronic mitral regurgitation

inf.endocarditis prophylaxis

enalapril

diuretics

nitrates

Acute mitral regurgitation

sodium nitroprusside

furosemide

intraaortic balloon counterpulsation

These are just some cases, TRy to make your own FORMAT etc etc

CCS case from somebody who took test recently

1.

8 hours old baby showed vomiting after feeding, low muscle tone, extremities blue, low cry sound. PE showed low ridge of nose, I-II grade heart murmur. check every thing including upper GI series, ECG, echocardiogram, result j°OKj± but not check abdominal x ray or ultrasound. Karyotyping found Down Syndrome. Educated Parent for feeding, genetic counseling and case closed.

2.

40 yo female visited office c/o palpitation and fatigue with recent hx of URI. PE: bilateral heart failure. ECG: all terminal low voltage and echocardiogram showed four heart

chambers enlargement and mild pericardial effusion. ESR increased. CXR showed bilateral lung base infiltration and one side plural effusion. Admitted to ICU and treated heart failure including lasix, ACE inhibitor, ibuprofen etc. Case not closed ;*..

3.

80 yo male drove his car into a electric pole with mild injury and was sent to ER. Pt was OK with everything except confusion. PE found mild injury with normal Bp and heart rate and lung/abdomen. Check Cervical x ray, CXR, head CT, chem 7 etc with no abnormal findings. Pt suddenly have heart rate 30-40/min. ECG found 3rd heart block and pace maker was given and pt was admitted to ICU. At this time heart rate back to 70-80/min but pt still confusion. Counseled cardiologist and case was closed. (should order abdominal CT to rule out internal bleeding?).

Let's discuss these trouble cases and some one gives more appropriate management.If the discussion is productive, I'll try my best to obtain and post more recall question. Hopefully, everybody in the forum work harder and join force to help each other.

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#22

Old 09-23-2003, 11:32 AM

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Batch#5

Dilated cardiomyopathy post-viral case

Hi!

I think dopamine or dobutamine for acute CHF is a good choice. Also, consider heart transplant if severe persisting HF (consult, thoracic surgeon, informed consent, living will , pre-surgery blood work. Also, water restriction & Lasix if water in lungs. Oxygen & nitrates IV of course.

Any comments?

MVA Case

I think what u did was good plus echocardiogram (tamponade), and chest ultrasound (aortic rupture). Triple X-rays of cervical spine, CXR(u did it) & pelvis are classic x-rays in all kind of trauma patients. We can have confusion after trauma without any obvious & visible cause on CT, conservative management.

Thanks for cases,
Any comments?

I worked on these three cases, hope they are correct

1. Working flow:

PE: whole body: general appearance, HEET, lung/heart, abdominal, extremities

Order: CBC with differential

U/A

Electrolytes including Na, Cl, K, Ca, P, Mg

ABG for acidosis

Serum Glucose

CXR and abdominal XR

EKG

Ultrasound of abdominal and Echocardiography

Management: Nothing by mouth

NG with suction

IV fluid

$\frac{1}{4}$ NSS IV

10% Glucose IV

Surgery consultation

Further management: Karyotyping

Education parents on feeding, genetic counseling, cardiological follow-up.

Transfer to surgery ward for duodenotomy

Diagnosis: Down syndrome

Duodenum atresia

Ventricular septal defect

2. Working flow:

History and PE: focused on general appearance, edema, lung/heart

Order: EKG

CXR

ESR, CRP

TSH

Chemical panel

Liver function

BUN/Cr

Echocardiography

Management: admit patient to ICU

Pulse oximetry

Mask O2 inhalation if SOB

Bedrest

Na restrict to 2 g/day

Silax

Captopril

Dobutamine IV

Nitroglyceride IV

Digoxin if heart rate is fast

Education on diet, exercise, and pneumonia prevention

Diagnosis: Cardiomyopathy

Heart failure

3. Working flow:

History and PE: GCS scale, lung and heart, abdominal

Order: Cervical AP and lateral views

EKG

Admit to ICU

Cardiometry

Pulse oximetry
NSS IV
Pace maker insertion
CXR
CPK, CPK-MB, troponin I (MI protocol)
CBC with differential
Chemical panels
TSH
ABG
U/A
BUN/Cr
Liver functions

Management: Hearing and visual testing
CT head
MMSE
Cardiologist consultation
Education patient on safety of driving and living environment and medications.

Diagnosis: A-V conduct block
Mild head trauma
Delirium

Alzheimer pt drugs and side effects given. I selected don't give Aluminum containing medications....

as I have seen it some where.....had no idea about....the other medications.....

here are some meds for dementia/alzheimer June 22 2003, 12:06 PM

Management: Specific concerns in Dementia
Dementia Related Malnutrition
Behavior Problems in Dementia
Agitation in Dementia
Sleep Problems in Dementia
Wandering Behavior in Dementia

Management: Medications

Cholinesterase Inhibitors

Efficacy

Improve neuropsychiatric scores 7 points

Seven point improvement equals ~1 year of decline

Benefits may persist for 1-2 years

Rogers (1998) Arch Intern Med 158:1021-31

Agents

Donepezil (Aricept)

Rivastigmine (Exelon)

Galantamine (Reminyl)

Tacrine (Cognex)

Not first line due to hepatotoxicity

Vitamin E

Vitamin E 400 to 1000 IU bid

Slows functional decline

Alternative: Selegiline (Eldepryl) 10 mg PO qd

Vitamin E is less expensive and as effective

NSAIDS (insufficient evidence to date)

Netherlands Study (n=6989 over age 55, for 8 years)

Continuous NSAID use decreased Alzheimer's risk

Relative Risk Reduction 80% for >2 years of use

Aspirin did not confer same benefit as NSAID use

In'tVeld (2001) N Engl J Med 345:1515-21

Johns Hopkins Retrospective study (n=209)

NSAIDS (n=32) slowed Alzheimer's progression

Based on MMSE, Boston Naming, and Benton scales

Rich (1995) Neurology 45:51-5

Alternative Medicine (insufficient evidence to date)

Ginkgo Biloba 40 mg PO tid

Appears mildly effective in improving cognition

Appears safe over one year of testing

Reference (Study: n=327, DB PCT)

Le Bars (1997) JAMA 278: 1327-32

Sleep Disturbance

Trazodone 25 to 150 mg PO qhs

1.

60 yom with colon ca came admit in hosp. for chemo. in hosp. During stay, he develop fever and productive cough. He was dx as pneumonia and tx with antibiotic. Pt develop SOB in last couple of hours. RR 28, BP and HR are NL.

Tx: O2 and IVF

EKG, CBC, Chem 7 are noncontributive. Pulse Oxi show O2 sat 90%, CXR: resolving pneumonia of MRL.

V/Q: high possibility of PE

Tx: heparin, warfarin, revisit pt in 1 hour
still sob, same vital

Tx: tPA, revisit in 1 hour

still sob, same vital

the case closed.

What is going on here?

I think you managed this patient right.

SOB probably due to pulmonary embolism also considering the toxicity of the chemo drugs such as bleomycin, which is toxic to lung, or dauxorubicin, which is cardiac-toxic. Generally, I agree this is the PE case.

Management: CBC with differential

ABG

U/A

Electrolytes with BUN/Cr

EKG

CXR

HRCT

P/E

PT, TT, aPTT, INR

Duplex ultrasound of legs

Order: O2 inhalation

Heparin

Warfarin

Monitor PLT, TT, and INR

Repeat ABG

Educate patient on anticoagulant use

If ABG is better, reassure patient because SOB could be an objective or subjective.

This is all I can think of. tPA usually only used when there is hemodynamically instability and within several hours of symptoms.

Suggestions

ABC

Thanks for the thought.

I also thought about pul. fibrosis due to chemo. The onset should be gradual. But this has a acute onset.

Pericarditis? Pt has not JVD and edema.

Another possibility is tumor emboli due to pt's hx of colon ca. This kind of PE will not be responsive to heparin tx. But I don't know how to tx.

I still have no idea what is the cause of SOB.

What is your thought about the other 2 cases?

Let's work on this recent CCS on the "step by step" rather than a few word comments. Someone could give detailed management and other provide "make up". If the dicussions are healthy. Mor to come.

1.

60 yo male in patient with colon cancer developed right low lobe pneumonia (fever and productive cough) during chemotherapy. His pneumonia was treated with antibiotics and improved significantly. Patient suddenly had SOB about two hours ago and you were called to see the patient. CXR showed the resolving infiltrate in right low lobe. Pt had normal Bp, and fast RR: 28/min. Immediately started oxygen and iv fluid. Ordered pulse oximetry (90% sat), ABG (Po2 down), EKG (non-specific), CXR (same), CBC, Chem 7. Then order V/Q scan which showed high probability of PE in right upper lob. Started heparin, iv and coumadin. Waited one hour to re-check patient who still had SOB. Vital signs and pulse oximetry were not changed. At this time, started Tpa (thrombolysis). One hour later, patient still had SOB and vital signs did not change. Case was going on and on. Finally time was out and case was closed.

2.

20 yo female came to office c/o of fatigue and other symptoms which was not related ITP. However, platelet was found very low (20,000) during the regular work up (CBC, Chem 7, UA, ECG, CXR, et al). Then checked the coagulation profile (normal). BT prolonged, Anti-platelet Ab (+?). Gave prednisone, po and IVIG, iv. Sent Patient to home for one week follow up (should have admitted to floor). And case was closed.

3.

60 yo male with hx of depression came to office for the regular check-up. But his looked fatigue and has not seen Dr. for long time. Complained to have heart burn sometimes. Gave the full PE and found "pale" and occult test +. Lab found minor anemia. Started low GI work up with barium enema and colonoscopy which were both -. Then did upper endoscopy which showed a ulcer in duodenal and biopsy with H. pylori +. H. pylori Ab + and urea breath test +. Started to treat patient with amoxicillin + azithromycin + omeprazole, ferrous and sent patient to home for one week follow up. When patient came back, it was found the occult was still positive. Did sigmoidoscopy which was also -. CBC still showed mild anemia. But patient claim that heart burn was improved. Case was going on and on and finally the time was out. Case was closed.

4.

60 yo female school principal was sent to ER by her boyfriend who found that she was unconscious in the office with a bottle of alcohol and several bottle of drug without label. Gave "ABC" including intubation and did PE. Found pupil enlarged and RR 20. Ordered alcohol level (300) and serum drug screen (-) ABG, pulse oximetry, etc. At the same time did gastric lavage + charcoal and found yellow color fluid without pill. Gave triple treatment (naloxane + thiamine + Glucose , iv). Patient was still unconscious. Then treat alcohol. Patient was still not improved and at this time only 5 min left. Order hemodialysis and case was closed.

My work on three cases. hope this can a little more help.

Case 1. Von Willebrand's Dis.

CBC
BT
PT
PTT
Factor VIII
Factor XI
VWF antigen
Ristocetin cofactor activity
Factor VIII:C

Admit to ward
IV line with normal saline
Desmopression (DDAVP), iv
Recheck patient
If severe, give cryoprecipitate Factor VIII or vWF

I am not sure whether estrogen, iv can be used in menorrhagia caused by von Willebrand disease and I check ref and could not find its use in this dis.

If patient is improved, discharge to home

Advice: avoid NSAID which causes or increases bleeding in this dis.

Ferrous, po

Advice iron riched diet

Educate pt about this dis

Genetic counselling for family

Follow up in one week

Case 2. Endocarditis complicated with pneumonia

CBC

Blood culture

Sputum Gram stain

Sputum c/s

Chem 12

LFT

UA

ECG

CXR

Echocardiogram

IV line + D5 normal saline

Nafcillin IV

Penicillin IV

Gentamicin, IV

If allergic to penicillin, Vacomycin IV

Admit to ward

Recheck Pt and lab results

If pneumonia not improved, change antibiotic based sputum c/s and blood c/s

If 5 min. left

Check HbsAg

HCV

HIV

Counsel for drug abuse

Case 3. Sickle cell crisis

If pt is very sick

O2

IV line

CBC

Reticulocyte

Serum bilirubin

H electrophoresis

Blood culture

UA + urine c/s

Mycoplasma titer

Chem 12

ECG

CXR

IV fluid D5 1/2 or 1/4 NSS

Morphine or meperidine, IV

Cefotaxime, IV

If HB $\leq$ 7, blood crossmatch and transfusion

Admit to ICU

Order MRI for painful arm to r/u osteomyelitis

Follow up patient and check more results of lab

Patient can be discharged 72 hours later if improved and

Change antibiotics to oral (cefto)

Influenza vaccine and check immunization status and make it up if missing something

Penicillin for prevention

Genetic counsel and education patient/family

Comments are welcome

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#23

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given below are PK's Cases:::

U CAN SEE HOW 2 PEOPLE have different approaches with the same cases

CCS 1)...

a 13 yo female came to office with mother with c/o increase amount fo bleeding and weakness. . Period are heavy from last two time. C/o back pain and taking some NSAID.

Feeling week and some pale.

H/o of father bleed excessively in past during dental extraction. Two brothers are ok.

My provisional Dig was VONWILLEBRAD DISEASE.

I will briefly tell what I did and where I found problem with soft wear of CCS.

1) CBC, Preg test, ua, sma7. pt, ptt

2) result shows anemia Hb 8, pt normal ptt slightly elevated and preg neg. PLT ok. I ordered BT , factor VIII, XI, von willibrad factor, transfer to hospital. Repeat Cbc in 2 hours . IVF, type and cross

3) BT was 17, I started DDAVP cryoprecipitate, transfuse one RBPC.

4) Pt ok in in next 6-8 hors bleeding reduced and feeling better.

5) could not DC pt but advised general counseling age appropriate and counseling to brothers, watch for bleeding in future, avoid ASP. etc

CCS 2)

a 45 yo male. MVA. No seat belt, steering broken, no loss of consciousness pt breathing ok, pain on chest bruised, conscious.

My initial impressions was Cardiac tamponade or Aortic rupture.

1) Did ABC, IVF, oxygen, cervical spine precautions,

2) cbs, EKG, , sma7, pt , ptt, blood alcohol level, xray chest, aary extremities, spine, abd xray et, VS, m onitoring. Pain killer

3) chest xray sternal fracture, all ok, pt some SOB and distress,

4) Ct chest, called ortho,

%0 orths said no intervention needed, Ct showed fluid in pericardial space

5) stat pericardiocentesis, admit to ICU, monitoring,

6) pt got better. Next day much better

Again time is very short in CCS , I could not do repeat CT or DC pt . B/c when we orders so many thing its take time to see result and by the time case end.

7) Did some counseling, seat belt, age related and etc

CCS 3)

7 yo Black kid with arm pain, chest pain, fever, mild distress (office)

pt know case of sickle cell disease and on prophylactic penicillin and had pneumo vaccine.
1) cbc, sma7, ua, chest xray , ul abdomen, LFTs, bilirubin, ivf, oxygen, meperidine.
i did not order peripheral smear or Hb electrophoresis as knowing that its known case of SSD and we are going to see sickle cell.

My prov Dig was SICKLE CELL CRISIS AND ACUTE CHEST SYNDROME

2) Hb 7, last was 8. Transfer to hospital with continue oxygen , meperidine iv, ceftriaxone , IVF
pt better next day. Dc iv meperidine, started PO ,
3) advised Hydroxyurea and hydration.)-
Again it's hard to keep track with time of soft wear and to understand when to dc drug or dc patient.
4) did some counseling with drug adherence, hydration Dc ceftriaxone and stated PO, was already on PNC and vaccine.

CCS 4) A 35 yo hispanic female, s/p repair of femur fracture, next day nurse said

UOP 80 cc in last 8 hours. Pt ok but c/o some pain.
Other exam ok. pT IS ON SOME CEPHALOSPORIN(PROBABLY CEFOTAXIME AND SOME PAIN KILLER which was not apparent NSAID, was like phenylpyrazone ?? of Meperidine (dont remember exactly).
MY PROV DIAGNOSIS WAS ATN

1) did initial labs, Urine creatinine, urine eosinophil, urine sodium (did not do FeNa) .
2) there was granular cast and no leukocyte, so I ruled out interstitial nephritis and urine NA was 45. BUN 28 and creat 4.5
I was sure its renal Failure due to intrinsic problem and culprit is either cefalo or pain killer. I was not sure pain killer is NSAID or not so i d/c cephalosporin.
I am not sure I Did right or wrong. I checked and did not see cefalo cause ATN, they cause nephritis.
3) continue with Furosemide and fluid and some basic counseling
Tried to counsel to avoid nephrotoxic but could not.
Final diagnosis I made ATN and Renal failure.

CCS5)

57 yo WM c/o mild cough , no other symptoms, no weight loss, h/o smoking but quit 3 years back, mild fever.
Chest exam with decrease BR on left base
My initial impression was b/w CAP or cancer
1) started with simple test CBC, sputum gram stain. ua, chest x-ray .eat,
CBC with wbc high, net, chest xray with lft lower consolidation and sputum with big amount of gram pos cocci.

I treat with Azithromycin, cough syrup and f/u in one week . also orders sputum c/s
2) did not get well in 10 week , c/o some blood in sputum. . Did Ct chest and found mass at Lt lung.
3) request bronchoscope , consult oncologist and
diagnose as Post obstructive Pneumonia and Lung cancer.
By that time case finished.

CCS6)

A 72 yo with mild progressive SOB, hx of HTN and MI , on enalapril , office, PND and otherwise ok.
On exam some b/l pitting edema and no JVP or other s/s of acute heart Failure or Pulmonary edema.

My provisional diagnosis was Cong. heart failure sec to HTN or IHD

- 1) CBC, Sma7, cxr, ekg , echocardiogram, lipid etc as an outpatient.
- 2) results showed hypertrophy, axis dev, akinesia , EF was not given in report.
- 3) started on next visit in 3 days, HCTZ and Digoxin, counseling few things , low salt diet, exercise, compliance with drug and f/u in 2 weeks.
- 4) pt was better, I checked sma 7. (I did mistakes and forgot to see Dig level but there was no /s/ of toxicity) pt was better.
- 4) f/u in 4w, and 3 months pt better.

Final Diag CHF (I did not add B blocker b/c was not sure about EF and he was already on ACE inhibitor. For got to add ASA too.

CCS7)

a 45 yo IV drug abuser, fever, SOB, track marks

My initial impression was Acute bacterial endocarditis (like every one will do)

1. ivf, oxygen, orders initial test , Blood c/s, cxr, cbs, urine tox, hep panel , VDRL, etc
- 2) started on iv nafcillin and gentamicin.
- 3) admitted to ICU (I don't know floor was better, let me know)/with cardiac monitoring.
- 4) did not get temp down next day. Cont AB and send another set of Blood c/s. consent for HIV test. orders Echo, showed, vegetation on TV.
again its very hard to keep track of pt and what test to order here. its theoretically looks easy but soft wear is strange. May I did not do much practice, but I did practice. I could not see result of V Blood c/s in one week. Time was running.
So I changes AB to Vanco and Genta b/a pt was still having fever.
- 5) did some counseling, safe sex, drugs etc etc, HIV test result not came back but hep and vdrl was negative.

My Final diag. was Acute Bacterial Endocarditis, I did two important steps like blood c/s and start AB before result which are life saving. I did know this is what USMLE want to see or to manage case entirely which was difficult for me.

- 4) in one week pt temp same

CCS8)

35 yo legal assistance female with non bloody diarrhea
weakness and pain in RLQ,

My initial impression was, CROHNS disease

1) did usual lab after IVF. LFT, CBS, PT, stool ova nd parasite, c/s, sma7.iron study, b12, FA

2) bi2 was low, iron very low anemic, mass on RLQ, abd series ok.

3) did barium (upper GI) some time we can do colconscoy or sigmoid, I choosed to do Barium

, admit to ward, NPO, TPN, B12, Iron,

4) barium neg , did colon scope showed ileum with cobble stone pattern no mucosa infalmed.

5) stated Masamine and predinisone and all nutritional aids.

6) counseling few things, high fiber diet. and drug compliance and education.

could not f/u or DC . It was chronic problem , to DC pt and f/u . B/c management takes time and every case finished in 1-20 minutes or earlier

Finla Diag was Crohns disase

I mean I could not see how pt did and long term follow up . How much it is imporant in CCS. ??

CCS9)

45 yo female with discharge/ itching came to office other wise healthy
healthy and last pap smear was 15 months back and normal

My initial Impression was Bacteril vaginosis

1) did preg test, ua, koh preo, wet mount smear, CBC

2) showed no huphes ar trichomonoas and lot of clue celle

3) treated with Meteo gel

4) Pt was happy in next 10 days.

5) Scheduled Pap smear and mamogram in next mont (to get rid of infaction.

General cousselling.

New ccs case try to solve

1.

middle aged lady c/o pain in the small joints of the hand and SOB and fever.

PE

labs;cbc, Rh factor, ANA,CXR,Chem7,EKG and then admitted to ward from the office (as she was mildly breathless and had fever)

cxr showed small pleural effusion

needle aspiration of pleural fluid and sent for analysis.Came as abundant neutrophils in pleural fluids,Low PH, Low sugar,protein (do not remember)

Patient was relieved of SOB immediately after needle aspiration.

Rxed with antibiotics.IS this correct?

For small joint pain started on indomethacin

Before Rh factor and ANA results time ran out.Soft ware was so slow.

2.

this is a case appeared before several times.DKA with UTI.

In this case DKA was managed well. the patient was started on TMP/SMX for UTI .But the patient kept on complaining about dysuria , difficult and discomfort in passing urine even on the second day.What should you do about this?

When you manage DKA should you catheterize the patient and monitor ?? But since this patient is having UTI can we or should we do it??

3.

9 month old baby presented with fever and cough with pneumonia apparent on Cxr.

What empiric antibiotic do you start??

test taker started on Ampicillin and gentamicin but fever didn't subside on second day.

How do you test a sputum sample in a baby in CCs .Do we just type sputum c/s. or should we say gastric aspirate as you cannot get a sputum sample from a baby

4.

In a suspected acute prostatitis case how do you test Prostatic fluid.Do you get it by prostatic massage.But one test taker had done it and clerk indicated that it was very painful to the patient.So how do we get a prostatic fluid sample?

above were some doubts that one test taker has had.your input is appreciated.

lady with joint pain and SOB

It looks like RA but then because the pulm/pleural involvement, it should r/o SLE. SLE has often involves pulm, pleural and renal etc, whereas simple RA rarely affect lung and renal. So if RF come back neg, should order C3, UA and renal function test to r/o SLE.

Treatment is NSAID, steroid, antimalaria. If only small amount of pleural fluid present by imaging etc, usually it is necessary for fluid analysis at first round.
comment?

think about SLE....

you may need to order anti-ds anti-smith, ANA first. you may need prednisone to control the flare-up.

your case closed early because you think it is RA.. no morning stiffness and other typical sx make RA less likely.

Acute bact. prostatitis

The diagnosis of acute bacterial prostatitis (ABP) is based primarily on clinical findings, in association with positive results on urinalysis and urine culture.

So treatment with fluoroquinolone or Bactrim should be started with high clinical suspicion and UA when waiting for urine culture, if wanted.

Care must be taken to avoid vigorous prostatic massage in a patient with suspected ABP to avoid bacteremia and sepsis, this is probably the reason the patient does not want the massage.

But u/a was NL. So had no choice but to do.....

prostatic fluid analysis. Culture takes time. patient had dysuria severely.

So my Question is if you need to test prostatic fluid you need to do a prostatic massage. Isn't that right?

Prostatic fluid, massage

Yes. If you have to get prostate fluid then do a massage to get about 4 drops into a slide.

9 m old fever and pneumo on CXR

Probably need to treat with ceftriaxone to cover pneumococcus, H.infla and S.aureus in this age group, while do sepsis work up to r/o bactremia etc. Outpatient can be treated with amoxi (or with clavulanate) or erythromycin plus sulfasoxazole. Ampicillin and gent are

mostly used empirically for less than 2 month old. It is difficult to manage infant/toddler has fever with/without focal infection. This is from Kaplan note.

Please comment.

Working flow for acute prostatitis

PE: extragenital examination, rectal examination

Order:

CBC with differential

U/A

Urine culture and sensitivity

Blood culture may be needed

Also test gonorrhea and syphilis if indicated by sexual history

Management:

Treat this patient as outpatient

Acetaminophen

Ciprofloxacin po

If suspected of chlamydia infection or gonorrhea, partner may need treatment as well

Follow up patient in 3 days

Adjust antibiotic according to sensitivity and the total length of antibiotics should be 30 days.

Educate patient on: Adequate fluid intake, STD and safe sex

Follow up patient in one month for regular check up including rectal prostate examination.

Final diagnosis: acute bacterial prostatitis.

Prostate massage is detrimental and contraindicated in acute bacterial prostatitis.

The following information is from emedicine:

Etiology: Most infections (82%) involve only a single bacterial organism. Occasionally, 2 or 3 strains of bacteria may be involved. The organisms primarily responsible for ABP also are those responsible for most urinary tract infections. The most common causal organisms for ABP include the following: Escherichia coli, Proteus mirabilis, Klebsiella

species, *Enterobacter* species, *Pseudomonas aeruginosa*, and *Serratia* species. Of these, *E. coli* is involved most often.

Obligate anaerobic bacteria and gram-positive bacteria, other than enterococci, rarely cause ABP. *Staphylococcus aureus* infection may occur in the hospital due to prolonged catheterization. Other occasional causes include *Neisseria gonorrhea*, *Mycobacterium tuberculosis*, *Salmonella* species, *Clostridium* species, and parasitic or mycotic organisms. *N. gonorrhea* should be suspected in sexually active men younger than 35 years.

Clinical: ABP usually presents as an acute illness with moderate-to-high fever, chills, low back and perineal pain, urinary frequency and urgency, nocturia, dysuria, and generalized malaise. Arthralgia and myalgia may accompany these symptoms. ABP also may result in acute urinary retention due to varying degrees of bladder outlet obstruction. The diagnosis of ABP is based primarily on clinical findings, in association with positive results on urinalysis and urine culture.

Rectal palpation usually reveals an enlarged, exquisitely tender, swollen prostate gland, which is firm, warm, and, occasionally, irregular to the touch. Care must be taken to avoid vigorous prostatic massage in a patient with suspected ABP to avoid bacteremia and sepsis.

Prostatic abscess is a potential indication for surgery. Prostatic abscess is an infrequent but well-described complication of ABP. Medical management often is not successful. Transrectal or perineal aspiration of the abscess is preferred and often is effective, especially if symptoms do not improve after 1 week of medical therapy.

Contraindications: Performing a prostate biopsy is contraindicated in suspected ABP because of the potential complication of seeding the bacterial infection in adjacent organs. Furthermore, prostate biopsy is extremely painful and may cause gram-negative sepsis.

Lab Studies:

- Prostatic secretions contain large numbers of leukocytes and fat-laden macrophages.
- Urinalysis, which shows leukocytes, and a positive result on urine culture are essential for diagnosis.
- Occasionally, blood culture results may be positive.
- Increased serum prostate-specific antigen (PSA) levels also are found but should not be used as a screening test for prostatitis.

Imaging Studies:

- Imaging studies, including a CT scan of the pelvis or prostate ultrasonography, should be reserved for those cases where laboratory analysis is equivocal or when no improvement is observed following medical therapy. Ruling out complications of prostatitis (eg, prostatic abscess) is a strong indication to proceed to imaging studies.

Diagnostic Procedures:

- Performing a prostate biopsy is contraindicated in suspected ABP because of the potential complication of seeding the bacterial infection in adjacent organs. Furthermore, prostate biopsy is extremely painful and may cause gram-negative sepsis.

Medical therapy: The intense inflammation in ABP makes the prostate gland highly responsive to antibiotics, which otherwise penetrate poorly into the prostate.

Hospitalization is required for patients in whom acute urinary retention develops and in those who require intravenous antimicrobial therapy.

The choice of antibiotic is based on results of the initial culture and sensitivity. However, initial therapy should be directed at gram-negative enteric bacteria. Useful agents include fluoroquinolones, trimethoprim-sulfamethoxazole, and ampicillin with gentamicin.

Antipyretics, analgesics, stool softeners, bed rest, and increased fluid intake provide supportive therapy. A Foley catheter can be inserted gently for drainage if severe obstruction is suspected. A punch suprapubic tube can be used if a catheter cannot be passed easily or is not tolerated by the patient. The catheter can be removed 24-36 hours later.

If the initial clinical response to therapy is satisfactory and the pathogen is susceptible to the chosen antibiotic, treatment is continued orally for 30 days to prevent sequelae such as chronic bacterial prostatitis and prostatic abscess formation.

For IV therapy, use trimethoprim-sulfamethoxazole (Bactrim), 8-10 mg/kg/d (based on the trimethoprim component) in 2-4 intravenous doses bid, tid, or qid until the culture and sensitivity results are known. An alternate regimen is gentamicin with ampicillin 3-5 mg/kg/d IV (gentamicin dose divided tid and 2 g ampicillin divided qid). After the patient is afebrile for 24 hours, an appropriate oral agent can be substituted for an additional 30 days.

For oral therapy, use trimethoprim-sulfamethoxazole (Bactrim), 160 mg of trimethoprim and 800 mg of sulfamethoxazole, PO bid for 30 days. Use ciprofloxacin, 500 mg PO bid; norfloxacin, 400 mg PO bid; ofloxacin, 400 mg PO bid; or enoxacin, 400 mg PO bid for 30 days when clinical response is favorable.

Complications:

Prostatic abscess is an infrequent but well described complication of ABP. Although very rare, it most often occurs in patients who are immunocompromised, patients who have diabetes, patients with urethral instrumentation or prolonged indwelling urethral catheters, or patients on maintenance dialysis. Coliform bacteria, especially E coli, cause more than 70% of prostatic abscesses. A prostatic abscess should be suspected when worsening clinical symptoms follow an initial favorable response to treatment of ABP or a fluctuant mass is developing in the prostate gland. The presence of the abscess is confirmed by transrectal ultrasound.

Once an abscess is diagnosed, anaerobic antimicrobial therapy should be added to the treatment regimen. Clindamycin intravenously at 600-900 mg q8h or orally at 150-450 mg q8h is a good choice. However, medical management often is not successful.

Transrectal or perineal aspiration of the abscess is preferred and often is effective, especially if symptoms do not improve after 1 week of medical therapy. Transurethral resection of the prostate and drainage of the cavity is another approach. Recurrent abscesses are rare. The abscess should be allowed to drain and should be monitored closely if a spontaneous rupture occurs into the urethra.

Other potential sequelae of ABP are progression to chronic prostatitis, septicemia, pyelonephritis, and epididymitis.

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Batch#7

SLE work up

Lab work:

CBC and Chem7

U/A

LE cell, ANA, anti-ds DNA, anti-Sm, VDRL

C3 level, ESR

LFT

BUN/Cr

Pleural fluid analysis

Images:

X-ray of the affected joints

Chest X-Ray

Echocardiography

Others:

ECG

Skin biopsy if possible

Kidney biopsy if needed

Diagnosis: SLE

Management:

Admit to ward

Aspirin for fever and arthritis

Prednison 60 mg po

Azathioprine PO or cyclophosphamide IV

Consult rheumatology

Patient education and counsel about exercise and possible osteoporosis related to corticosteroid use.

I do not have the software yet, therefore, someone else there, would you please run this workout for me and other people.

Comments welcome!

Which one of the following tests is not always recommended in the work-up of a patient suspected of having dementia?

- A. Complete blood count.
- B. Imaging test of the central nervous system (computed tomography or magnetic resonance imaging).
- C. Mini-Mental State Examination (or other cognitive test).
- D. Liver function tests.
- E. Urinalysis.

D---- > LFT

The rest of the listed have to be done to work up a patient with Dementia

CCS

INtracerebral hemorrhage

patient presents to ER with headache, nausea, vomiting, altered sensorium, motor sensory changes cranial nerves

1. Oxygen iv access cardiac and pulse monitor
- If vitals show elevated bp iv nitroglycerin

2. rapid PE, heent(elevated ict), cns ,cvs ,lungs

3. stat ct without contrast

cbc

chem7

coag profile

lfts

cxr

D/D trauma, hypertension , av malformation, aneurysm, caog disorder

4. mgmt imm. neurosurgical consult for craniotomy and evacuation of hematoma

medical management is not much benefit except

if elevated ict or expanding hematoma iv mannitol, dexta (no proven benefit)

awaiting surgery :-bedrest

npo

analgesics

adequate BP control

laxatives to prevent increase ict

nimodipine po started

other preop prep

if CT shows evidence of aneurysm/ av malf.

order angiogram

can someone add

this case has been asked.

30 years old female presented to the ER after taking Aspirin-----> CT scan showed ICH

this is a case of ICH and not SAH. Your management of SAH is fine.

INTRACEREBRAL HEMORRHAGE:

Interval History:

Orders:

.O2
.PULSE OX
.CBC
.CHEM12
.COAG
.IV Access/NS
.CT HEAD Without Contrast
.EKG
.CXR--- Portable
.UA
.A-LINE
.FOLEY'S
.VITALS
.If Stable----->> ICU
.VITALS
.NEURO CHECK q1HR (Software recognises)
.Elevate Head of Bed (Software recognises)
.Control BP only if >180/100
.Neuro Consult
.Anesthesia Consult
.Consent From Patient or Family
.Surgical Management

others correct me if I am wrong or missed something.

thanks

why to admit the patient to the ICU when he has to undergo neurosurgery?

and wat about preop MRI if aneurysm/ AV malf is suspected ?
sah was one of the considerations

Lab :
PT & PTT
bleeding time
LFT
ABG

If has nausea and vomiting - i/v prochlorperazine

I dont how stable was the Pt. -if needed intubation and mechanical ventilation to decrease ICP.

That's what I meant that only if patient is stable , should we move her to the ICU. But we will get the information in the ER itself once we start getting the result back and will base our plan on the labs and clinically and if her condition demands, will transfer to OR. I got this information from Fred Ferri. Your suggestions and input is Welcome.

Yes LFT can be added to the list. Coaug profile includes PT/PTT,Bleeding

CCS

Upper Gi bleeding

massive bleeding.Low Bp .Hx sugg. of eso varices.

IV access.(2 lines.But software doesn't allow 2 lines. So how to do this?)

Iv Ringer's lactate

Iv vasopressin(clerk doesn't identify octreotide)

Iv Vit K bolus

NPO

NG

labs: cbc

Lft

Chem 7

coagulation prof

blod type & cross matCh

If bleeding continues stat Gi consult.

UGIE

Endoscopic sclerotherapy

Both these can we order.Or do we have to wait for GI opinion.If they suggest. we order.Am I correct?

When pt stable transfer to ward.

If bleeding has stopped and stable d/c Iv fluids d/c Npo and start oral

Advice stop alcohol

refer alcohol anonymous.

please correct me if anything wrong or need to add more

Your orders are fine, you can add:

.foley's

.When you type Endoscopy---> software will ask for GI consult and then you can type in the reason for your consult

.Software does not recognise OCTREOTIDE or Somatostatin. IF you can find out let us know.

My understanding of Emergency Cases is that if you are in the right tract and if consult is justified, the case will end soon. If on the other hand if you get a prompt which tells you that the consult has nothing to offer, then either it is not required at all or you have to modify your management.

it is good at least you have come forward and went through the protocol of managing different cases. Because it is very difficult for me to type all 70 cases.No one except Texas and Radiance, wants to take the trouble of getting the protocol.

Let's keep it up.

Find out about OCTREOTIDE and Somatostatin

***** **

CCS

perforated peptic ulcer

PE

Orders

Iv line

Cbc/ chem 7/ s. amylase/s.lipase/ RBS/EKG/CXR/Abd xray/

bld type and croos mathc,

LFt

caog profilie

Ng

NPo

Iv meperidine bolus for pain relief (I am not sure of this)

GI consult

Prep for sx

In this case do we do UGIE to confirm the diagnosis?

before discharge counsel limit alcohol. No aspirin, life style modification

Please add or omit.

stop smoking

and follow up for GI consultation...

Clinical diagnosis

PUD perforation usually is made clinically with abd X ray showing subdiaphragm free gas. I do think we need UGIE to make the diagnosis.

Narcotic analgesic is important.

CCS

Diverticulitis

PE Iv access

labs:

cbc/u/a /FOBT/chem 7/xray abd erect decubitus/Blood culture

CT abd

Iv fluids

NPO

NG

IV antibiotics (Do you start even before CBc ? if so what Ab?for how many days? is it Iv Cefoxitin?)

Surgical consultation if no improvement or complications

later advice- high fiber diet

if patient presents to office and mild symptomstreat on outpatient basis.

Inv : cbc,chem7,fobt,ua

PO Cephlex and flagyl

high fibre diet antispasmodics

stool softener

and counsel exercise

If severe symptoms / admit to wards ...or if presents to ER:

iv access Iv RL

INV: CBC chem 7 blood culture& S fobt ua

ct abdomen

NPO ngst with suction reassure

IV Ampicillin flagyl-----wards

If patient recovers

dc ngst and npoobserve 24hrs soft diet

stable ..cancel iv and discharge on oral antibiotics

If not

repeat ct abdo to look for abscess and wait for sensitivity reports

abscess: drain

or once sens reports available : change antibiotics

On discharge antisp, diet,stool soft,exercise

and follow up 5-7days

when stable sigmoidoscopy,colonoscopy

if missed/...pls add

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#25

Old 09-23-2003, 11:36 AM

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Join Date: Jan 2003

Posts: 0

Batch#8

acute gouty attack

Step 1

Keep foot elevated

Labs

cbc,chem7,uric acid level, 24 h uric acid,u/a,
Synovial fluid-gm stain,c/s,crystals,glucose ,protein cellcount,
xray joint

Diet

Low protein(No options for low purine diet)

Avoid alcohol

Increased fluid>2L/day (no options for this)

motrin po

colchicine po(if no esrd)

corticosteroid if stillcomplaints of pain

Allopurinol 24 hour urin uric acid>800 mg

probenecid 24 hour urin uric acid<800 mg

Bed rest24 hour

Avoid aspirin

ref CMDT 2002 PG 839

Treatment of choice for Acute attack

is

NSAIDSIndomethacin is usually given.

C/I : PUD, Renal impairment and allergic history

Colchine is also given but not favoured due to its GIT side effects. Only effective in first few hours

Corticosteroids are best reserved for those persons unable to take oral NASIDs

Other :

bed rest for 24 hr
avoid aspirin
May need analgesics

Go for management between attacks.

Do we need to send this patient to the ward?, if he/she improves within the next hours
when to discharge and schedule follow up?.

CCS

Turner Synd (Office)

14 year girl never menstruated, short stature, chubby

INTERVAL HIS :---->Complete

WRITE ORDERS :

CBC
CHEM7
UA
CXR
EKG
ABD Ultrasound
TSH
LFT
KARYOTYPE
BUCCAL SMEAR
Check Ekg--- report comes in 30 min
Change Loc----->HOME
Appointment in 7 days

Pt back for appointment
Reassure Pt
Counsel Parent

Surgical Consult
Estrogen and Progestin
Change Loc----->HOME
Appointment in 3-6 months

My Questions :'

- 1.Genetic counsel-----> computer doesn't recognise
- 2.family education-----> computer doesn't recognise
- 3.Do we do X-ray wrist
- 4.Estrogen and progestin ----> what formulation
- 5.Anything to be added/deleted

genetic counsel - counsel abt birth control or contraceptionwill that be acceptable alternative ?

counsel parent - for family education

and wat abt echofor coarctation aorta?

*Agree, we will do wrist x-ray.

*I think we do echo only if EKG abnormal

*Please let us know the formulation for E/P, because computer only recognises different combination. My concept is not very clear with the combination.

Therefore for this case what formulation of both Estrogen and progesterone before and after fusion

Also since we are discussing contraceptives, for DUB,do we manage the girl with premarin. If yes what combination of estrogen and progesterone do we start after premarin. And if we don't give premarin, what is the combination of E/P.

coarctation not diag on EKG

Need to do Echo and fasting Blood sugar,
genetic consult is there.

can give estrogen and progesterone separately, only concern is make sure that you Rx low dose estro before fusion of bone.

***** *

CCS

Alz Dementia (Office)

INTERVAL HISTORY :----- >

.GA,HEENT,Chest/lungs,Heart,Abd,Ext,Neuro/Psych

WRITE ORDERS:

.CBC

.SMA7

.LFT

.FOLATE

.B12

.RPR

.EKG

.CXR

.CT HEAD

.UA

.Neuropsychiatric Test battery (Computer Recognises)

.Follow up the EKG and ask the patient to come back in 3 days. As far as patient is in safe environment, you can send the pt home.

Pt is back for the appointment:

. Start Aricept or Exelon

. Vitamin E

. Follow up in 4-6 weeks

. If patient is alone, you can ask for Home care

counsel regarding driving,safety at home and so on

U got to check thyroid profile...hypothyroidism is associated with mental slowing and memory difficulties.

second.... in terms of result of all these test...MOST of the result will come NEGATIVE if this patient has dementia..

u also have to rule out depression with is associated with PSeudo dementia..

lastly....if u decide to start meds ..start with Aricept..

exelon is associated with Serious GI s/e and u have to titrate dose very carefully
VIT e is not beneficial in ALzheimers dementia.

Some doctors do give Vit E ...

Apart from psychotropic medications and behavioral interventions, ChEIs, NMDA antagonists, and inhibitors of amyloid deposition, numerous other agents are proposed for the treatment of AD. These include free radical scavengers (based on the proposal that AD is caused by oxidative stress) and estrogen or selective estrogen receptor agonists (based on emerging evidence that estrogen has a trophic effect on certain neuronal populations that is lost after menopause). These 2 proposals are cited as justification of many practitioners' recommendation to employ high doses of tocopherol (1000 IU PO bid) in all patients and estrogen replacement therapy in postmenopausal women with AD. Emphasis should be placed on the fact that the common use of these agents in clinical practice is not mandated by federal or other institutional policy but reflects the widespread belief that they may be beneficial to patients

REF:<http://www.emedicine.com/neuro/topic13.htm>

Agree Vitamin E is given with Aricept

thanks for letting us know the S/E of exelon

i dont think VIT E is a standard of care,,,,u can give anything u want but it is not recom

In a trial including over 300 patients with moderately severe AD,treatment with Vit E (alpha tocopherol) or the selective monoamine-B inhibitor selegine was found to lower rates of functional decline.

I got this information from the hospital and the attending confirmed that Vit E is being given to these Patients.

Hope that helps.thanks

DUB (ER)

15 year old brought to the ER because of Vaginal Bleeding

Interval History:----- >

.GA,Skin,Breasts,Chest/Lungs,Heart/CVS,Abd,Genitalia,Ext

WRITE ORDERS :

.CBC

.CHEM7

.IV Access

.IV Fluids

.Serum HCG (Quantitative)

.Pelvic Ultrasound

.TSH

.Coagulation Profile

.IV Premarin

.If Stable----- >WARD

.Vitals

.Follow up Labs

.Patient Better

.D/C IV

.D/C Premarin

.PO Low Dose Estrogen/Low Prog

.Change Location-----> HOME

.Counsel Patient

.Appointment in 1 week

Friends, please add your input

My Questions:

- 1.which hcg do we do-Quantitative,Qualitative or Urine
- 2.Is the oral contraceptive combination of Low E/P OK
- 3.Anything to be added/deleted in this case.

thanks

i think the ocp should be low estrogen and high progesterone

if both are low the net effect of that ocp will be less.so its better to increase one and decrease another.we always use low dose estrogen. I think its better to use either medium or high dose progesterone

I think she needs Pap smear (if the pt is sexually active)

CCS

Cystic Fibrosis(ER)

By the time, you are through the first 3 screens, you kind of have an idea of what case it is.

INTERVAL HISTORY:---

WRITE ORDERS: ----->

- .O2
- .IV Access
- .IVF
- .CXR
- .CBC
- .CHEM7
- .ABG
- .SPUTUM---Gr St and C/S
- .Blood Culture
- .Sweat chloride
- .IV Ceftazidime and Tobramycin (Pending the Results)

If patient Stable, Change Location----- WARD

- .Vitals
- .Chest physiotherapy
- .Incentive Spirometry

- .Follow up the Sputum/Blood Culture and give Abx accord
- .pancreatic enzymes
- .diet supplements

Patient feeling better:

- .Counsel Deep Breathing Exercises
- .Counsel Patient
- .D/C IVF
- .D/C IV Antibiotics
- .Start PO Cefalexin or Clarithromycin or Augmentin
- .Change Location----- HOME

- .PFT
- .Influenza Vaccine
- .Pneumococcal Vaccine
- .Appointment in 7 days

Friends, suggestions Welcome

Please add-----> Albuterol inhalation in Orders

Good mgt Add pulse ox on arrival in ER and again before sending to ward.

CCS-Tuberculosis (pulmonary):
June 8 2003 at 9:16 PM

Tuberculosis (pulmonary):

- CXR
- order sputum AFB smear
- if + notify health department
- if sick adm. In solation with good ventlation.
- Start 3drugs + one if high risk.
- check sputum smear and culture weekly and then monthly once test negative.
- check close contact.(PPD)

The most common presentation is of reactivation of disease in the upper lobes. Tuberculosis can also present with lymphatic disease, osteomyelitis, genitourinary symptoms, military TB, TB meningitis, peritonitis, or pericarditis. Most cases are dir to reactivation and not to primary infection.

S&S:

Fatigue, weight loss, anorexia, low-grade fever and NIGHT SWEATS and cough.

DX:

Sputum AFB smear

Is made with testing of sputum for TB culture and drug sensitivity. Less definitive is a sputum that is positive for an AFB stain. Note that non-tuberculous mycobacteria may also be AFB-positive.

Serology testing elisa is new

Treatment:

1. notify health department
2. hospitalized patient should be put in respiratory isolation.
3. if resistance is a possibility (not $\leq 4\%$) then patient should be treated with at least 4 drugs. Once isoniazid and rifampin sensitivity is established, the patient can be treated with isoniazid, rifampin and pyrazinamide for 8 weeks, followed by 16 weeks of isoniazid and rifampin alone. For HIV + need to use for 9 months or 6 months beyond culture conversion. non HIV + 3 month after culture conversion.
4. pregnant women should not be treated with pyrazinamide or streptomycin (causes deafness in fetus). The appropriate regimen here is isoniazid, rifampin, and ethambutol.
5. patients under treatment should have a sputum smear and cultures checked weekly and then monthly once they test negative. If sputum is still positive after three months of treatment, suspect either noncompliance or drug resistance.

TB drugs:

1. Isoniazide- S.E. B6 deficiency(peripheral neuritis), and hepatitis – check AST and ALT.
2. rifampin- S.E. hepatitis, and rash- check AST and ALT.
3. ethambutol- SE. optic neuritis(reversible), and rash- check visual acuity
4. pyrazinamide-SE. hepatotoxicity and hyperuricemia- check uric acid and AST, ALT.
5. streptomycin- SE. 8 nerve deafness and nephrotoxicity- check vestibular function and BUN and creatinine.

TB skin testing:

Consider a PPD positive if:

1. ≥ 5 mm of induration in an HIV+ patient, in a contact of a known case, or in a patient with characteristic chest x-ray findings.
2. ≥ 10 mm of induration in immigrants from an endemic area, prisoners, homeless, IV drug users, nursing home residents, or in high-risk minorities.
3. ≥ 15 mm of induration in patients not in any of the high risk groups.

Treat with prophylactic isoniazid (300 mg for 6-12 months) if the patient has:

1. a new conversion to a positive PPD at any age.
2. a history of untreated TB or chest X-ray evidence of a previous infection.
3. a positive PPD in a patient less than 35 years old.
4. a positive PPD in a patient at high risk for active disease
5. a positive PPD in a patient with close contact to someone with active tuberculosis.

Rifampin is also used as prophylaxis in meningococcus meningitis – ciprofloxacin also can be used but not in children ≤ 17 years because of bone and ligament problem. Achilles lig.

Rupture.

≤ 35 yrs does not require LFT

= or > 35 yrs INH use must do LFT's (may be as high as 3x normal).

CCS- pid

June 10 2003 at 11:12 PM

young woman complaining of abdominal pain and vaginal discharge. dx: PID secondary to N. gonorrhea.

-Acute salpingitis

PE

Gen exm

Lungs

Heart

Pelvic/vaginal

Investigations

CBC with diff

urine pregnancy,

ultrasound – abdominal and transvaginal

gono/chly vag culture,

bl culture

SMA 7

ua and culture

pap smear

cervical culture

pelvic ultrasound

KOH slide and wet mount

HIV testing

Treatment

IVF

Admit to ward and order i/v antibiotics

Clindamycin and gentamycin

On discharge give counselling on Educate patient/family accordingly...

eg. exercise, smoking, drug use, safe sex; etc..

1. not all of pt need for in-pt tx

2. in-pt criteria: all nulliparous and adolescents, HIV+, out-pt tx no response, GI symptoms.

3. give doxycycline if tubo-ovarian abx+

4. cont. iv antibiotics for 48 h if symptom improving

Gastric ulcer bleeding

64yo female epigastric pain ibuprofen hx. For bursitis, stool ob positive.

PE:

vital signs: BP, Pulse, Resp. Rate, Temp. (order from order sheet)

appearance, skin, CV, Lung, Abd, Rectal

Investigations:

Monitor Hb and Hct q6h

CBC,

SMA-7 (BUN/Cr: >36---UGI bleeding)

stool guaiac-positive

PT,PTT,INR

LFTs,

CXR

X-ray abd

NG tube aspiration, NG Positive bleeding

Endoscopy (Sclerotherapy or endoscopic variceal ligation for bleeding varices.)

If still no Dx,

Active bleeding --- angiography

Inactive bleeding ---- GI series

NG negative bleeding

Sigmoidoscopy----- bleeding stoped----colonoscopy or BE

Active bleeding---angiography or radionuclides studies

Management

NPO,

IV access

NG tube,

IV fluid d51/2 NS

Chest X- ray transfer pt to ward

PT/PTT

Blood type and cross

Blood transfusion if needed

Therapy

treat underlying disease

Endoscopy - Sclerotherapy or endoscopic variceal ligation for bleeding varices.

SBE prophylaxis when there is risk factor.

No choice regarding avoid NSAID'

Only about aspirin

In aspirin list there is 'abstain from aspirin'

In avoid list "avoid oral aspirin"

clerk cant order > breath urea test

have to order H-pylori antibody serum.

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#26

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Batch#9

pid work up

Acute PID/ Acute salpingitis

-young woman complaining of abdominal pain and vaginal discharge. dx: PID secondary to N. gonorrhea.

-Acute salpingitis

PE

Gen exm

Lungs

Heart

Pelvic/vaginal

Investigations

CBC with diff

urine pregnancy,

ultrasound – abdominal and transvaginal

gono/chly vag culture,

bl culture

SMA 7

ua and culture

pap smear

cervical culture

pelvic ultrasound

KOH slide and wet mount

HIV testing

Treatment

IVF

Admit to ward and order i/v antibiotics

Clindamycin and gentamycin

On discharge give counselling on Educate patient/family accordingly...

eg. exercise, smoking, drug use, safe sex; etc..

1. not all of pt need for in-pt tx
2. in-pt criteria: all nulliparous and adolescents, HIV+, out-pt tx no response, GI symptoms.
3. give doxycycline if tubo-ovarian abx+
4. cont. iv antibiotics for 48 h if symptom improving

chf

congestive cardiac failure

-Pt with progressive SOB in office - CHF

-Middle age man with Decompensated Congestive Heart Failure seen in your office

PE:

As the person is in the office a complete H & P

Investigations:

1. EKG
2. chest X-ray
- 3 CBC
- 4 SMA 7/12
- 5 Lipid profile
6. LFT
7. Urinalysis
8. Cardiac enzymes
9. Echocardiogram

Treatment:

If patient is stable and doesn't require further workup or workup can be done outpatient then discharge patient home.

1. low sodium diet
2. lasix
3. digoxin
4. ACE Inhibitor

usual counselling and schedule f/u appt.

1. EF<40%→systolic, >40% → diastolic

2. Ca block for diastolic
3. beta-blocker not for acute
4. f/u: flu shot, check K level

PE

PE...trip to Australia

PE without classic pleuritic pain but with classic trip from Australia

PE

General examination

Lungs

CVS

HEENT

EXT

Investigations.

Chest x-ray

ABG

Pulse Ox

EKG

Ventilation-perfusion scan

Sma 6

PT/INR, PTT

(Protein c and s level

Anti Thrombin III not emergency but eventually

D dimer

Factor V assay)

Treatment in ER

1. Administer oxygen as soon as possible. (even before all the investigations are sent)
2. Heparin bolus, followed by infusion to maintain PTT X 2
3. Coumadin maintainain INR at 2.5-3

Transfer to ward

Continue anticoagulation and discharge when theraputic anticoagulation is attained and anticoagulation to be maintained for atleast 6 months.

Discharge

Educate patient/family accordingly, medication compliance.
eg. exercise, smoking, drug use, safe sex; etc..
Schedule F/U

PDR, this is all from previous posting about RA case, sorry no work flow..yet..

40 F SOB low grade fever, and wrists hurt->ESR+, RF-, ANA+ CXR shows LL Effusion
-> thoracentesis, (pt feels better afterword) low glucose, no bugs-> gave ibuprophen
and prednisone, got better =RA

middle aged lady c/o pain in the small joints of the hand and SOB and fever.

PE

labs;cbc, Rh factor, ANA, CXR, Chem7, EKG and then admitted to ward from the office
(as she was mildly breathless and had fever)

cxr showed small pleural effusion

needle aspiration of pleural fluid and sent for analysis. Came as abundant neutrophils in
pleural fluids, Low PH, Low sugar, protein (do not remember)

Patient was relieved of SOB immediately after needle aspiration.

Rxed with antibiotics. IS this correct?

For small joint pain started on indomethacin

Before Rh factor and ANA results time ran out. Software was so slow.

Liu: Looks like RA, but not sure why pleural fluid got infected..? is it common, or in
general, RA induced pleural effusion shd contain WBC as inflammatory process.... any
ref..(just like joint fluid analysis)

Jb: It looks like RA but then because the pulm/pleural involvement, it should r/o SLE.
SLE has often involves pulm, pleural and renal etc, whereas simple RA rarely affect lung
and renal. So if RF come back neg, should order C3, UA and renal function test to r/o
SLE. Treatment is NSAID, steroid, antimalaria. If only small amount of pleural fluid
present by imaging etc, usually it is necessary for fluid analysis at first round.
comment?

can you explain why the pleural fluid had lot of neutrophils?

It is an exudative pleural eff Rheumatoid effusion characteristics:

Turbid, 1000-20000 WBC, differential mono and polymorphonuclear RBC <1000, Glu
<40

you may need to order anti-ds anti-smith, ANA first. you may need prednisone to control the flare-up.

your case closed early because you think it is RA.. no morning stiffness and other typical sx make RA less likely.

CCS- TTP-

Thrombotic thrombocytopenic purpura:

Working flow:

History and PE

Lab work:

CBC with differential

Blood peripheral smearing

LDH, total and direct bilirubin

Direct coombs test

Cr/BUN

PT/aPTT

Dimer/fibrinogen

UA

HIV screening

vWF-cleaving protease activity

Images: Head CT without contrast if stroke is suspected

Management:

Admit patient

Plasma exchange

Prednisone

Aspirin can be used

Vincristine can be used for refractory case

Platelet should not be transfused unless intracranial bleeding

Consult hematology

Consult nephrology if dialysis is needed

Examine patient every day

Repeat CBC, LDH, bilirubin, Cr every 3 days

Discharge patient when all these are normal

Follow up patient in one week with CBC and LDH

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#27

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Batch#10

SAMPLE SOLUTION TO THE CCS QUESTIONS

CASE #1: 65-year-old white man with chest pain

Case Introduction: Essential Facts

- Patient is white, in mid-sixties
- Has sharp, right-sided chest pain, accompanied by respiratory distress
- He was brought to the emergency department

Comments

There is nothing that connects being white with having chest pain. This patient could have been of any racial origin and still present with these clinical features. However, the patient's age will affect our choice of differential diagnoses. Chest pain in an older man is more likely to be of cardiac origin than the same pain in young patients.

Possible differential diagnoses at this stage include

- Pulmonary embolism (PE) because of chest pain, respiratory distress
- Lobar pneumonia (chest pain, respiratory distress)
- Tension pneumothorax (chest pain, respiratory distress)
- Musculoskeletal chest pain (pain in a specific location)
- Pleuritic chest pain
- Cardiac pain (this is less likely, though possible. A patient with dextrocardia who develops myocardial infarction may have right-sided chest pain. However, since this test is based on clinical conditions commonly seen in practice, we are not going to be too concerned with this differential)

Initial Vital Signs: Essential Facts

- There is tachypnoea and tachycardia
- Blood pressure is low
- Temperature is normal
- The patient is obese (BMI of 29)

Comments

Pneumonia as a cause of this patient's chest pain is effectively ruled out because of the normal temperature. Still high on our list are PE, pneumothorax, and the other differentials listed above. Patient's obesity will be addressed at a later time

Initial History: Essential Facts

- Chest pain began 10 minutes before arrival at the ER

- This is the first episode of chest pain
- Patient has had chronic lung diseases that may predispose to pneumothorax
- Chest pain increases with respiration
- He was not involved in strenuous activities immediately before the onset of chest pain

Comments

Although, this pain increases with respiration, a musculoskeletal cause is unlikely, going by the patient's recent history. He is an accountant who suddenly developed an excruciating chest pain while at work. There is no recent history of chest trauma.

Because of his long-standing history of asthma and emphysema, we will add emphysema to his differentials, since the latter can cause a measure of chest discomfort, especially if there is associated chronic obstructive pulmonary disease (COPD). However, uncomplicated emphysema does not cause sudden sharp chest pain.

It is time to perform the physical examination. Click the button labeled Interval History or PE and select

- General Appearance
- Chest/Lungs and
- Heart/Cardiovascular

We are interested in the general appearance (this is standard when interacting with most patients. You should always examine the patient's general appearance). Moreover, because the primary complaint is in the chest region, we would naturally want to examine that area. Also, considering the patient's age and the possibility that his heart might be the cause of his problems, we want to examine the heart as well. We cannot do more detailed examination of other systems because this is an emergency. Press OK to confirm your choice.

History and Physical: Essential Facts

- Patient is cyanotic and in marked respiratory distress
- There is chest asymmetry, with hyper-resonance on right side. Breath sounds are also absent on that side
- Cardiac examination essentially normal
- Peripheral pulses present but weak
- No pulsus paradoxus (a fall in pulse amplitude with quiet inspiration)

Comments

Notice the results of physical examination. We seem to have enough reason here to believe that this patient has tension pneumothorax. However, we would still like to confirm this with further tests.

FAQ: Since this patient is in severe pain, and his vital signs are abnormal, why can't we just go ahead and treat?

Answer: Although this is a relative emergency, it is clear that we have enough reason to investigate the cause of the patient's problems further before we initiate treatment. First, we can still measure his blood pressure (although this is low). There is no pulsus paradoxus. We are not going to waste time on nonessential investigations however. It is important to try and establish the cause of patient's problems, if possible, before we initiate treatments.

Now, let us write orders. If the result of the History and Physical is still visible, click OK to close it. Next, click the button labeled Write Orders or Review Chart.

Next, click Order button at the bottom of the screen, and enter the following orders (one on each line):

- . Chest x-ray
- Oxygen
- Morphine
- ECG

Confirm the orders by clicking the Confirm Order button. For chest x-ray order verification, choose Chest x-ray, portable. Click OK. Urgency: stat.

Note: Although, Chest X-ray PA/lateral may give you more detailed information, it takes more time. Moreover, the patient has to be wheeled to the X-ray department before the films can be taken. Portable chest x-ray can be done right there at the ER, and it takes very little time.

For oxygen, choose Inhalation for route and Continuous for frequency. For morphine, choose Intravenous for route and Continuous for frequency.

Note: morphine is almost always given through the intravenous route for most conditions. In any situation where you have need to use morphine, consider this fact. Don't let the frequency that we chose mislead you. Continuous administration here means that it is given at fixed times (e.g. 6 hourly, 8-hourly, etc).

For ECG order verification, choose ECG 12-lead; Urgency: stat.

Now that we have initiated treatment, it is time to review that patient with the next available result. From our Order Sheet, we can determine that the result of the portable chest x-ray will be ready within 10 minutes. So let us advance the clock to that time.

Click the button Obtain Results or See Patient Later at the top of the screen, and choose Review Patient with Next Available Result. The test result is displayed.

Chest X-ray findings: Right tension pneumothorax

Next, we are going to write more orders for this patient. Click the Order button at the bottom of your screen and type thoracentesis. Scroll to the bottom of the form and choose Thoracostomy tube. Confirm your choice. The result of this procedure is immediately displayed. When you click OK, the result of the 12-lead ECG will be displayed, showing essentially normal findings.

It is now time to advance the clock, so we can re-evaluate our patient in 15 minutes. Click on the clock at the top of the screen and choose

- Re-evaluate case In, then
 - type 15 in the Minutes box (you may also use the upward pointing arrow to do this).
- Click OK

Now that our patient has been stabilized, we would like to perform an interval follow up before we admit him for further management.

Towards the left side of the screen, click Interval History button, and choose

- Interval Follow Up,
- Chest/Lungs under the Physical Examination section

The important findings this time are:

- Patient is a smoker (for 45 years)
- He has a positive family history of cardiac disease, hypertension, obesity, and stroke.
- As noted earlier, the patient is obese (he has a body mass index of 29)
- Patient does not engage in regular exercise (dyspneic after 1 minute of brisk walk)
- The chest is now symmetrical

Some of this information will come in handy when it is time to address the patient's health maintenance issues. For now, we would like to send him to the intensive care unit.

FAQ: Since the patient has been stabilized, why can't we just admit him to the ward instead of the ICU?

Answer: Under the British medical care system (and, incidentally, this is also true of many third world countries), we would have sent the patient to the ward. However, in the United States, patients like these are sent to the Intensive Care Unit.

FAQ: Why can't this patient be discharged home right away, since he has been relieved of his problems?

Answer: he has a chest tube in place. The general consensus is that the chest tube should remain in place until we are sure it is no longer needed (i.e it does not show any bubbles in the water seal.) Even then, some hospitals prefer to clamp the tube and observe for some more time, before they remove the tube entirely.

Click the Change Location button, and select Intensive Care Unit (ICU). Confirm move. Recorded vital signs are displayed (much better this time around). Click OK.

We must now add more treatment for the patient. Click Order Sheet on the left side of the screen, and Order button at the bottom. Enter the following orders (one per line):

- Albuterol (inhalation, continuous)
- Atrovent (inhalation, continuous)
- Advise patient, smoking cessation (routine, start now)
- Advise patient exercise program (routine, start later)
- Advise patient, weight reduction (routine, start later)

Next, we are going to re-evaluate the patient in 1 day. Click the clock, and advance the next evaluation to 1 day. The dialog appears telling you you have five minutes more, and asking for the final diagnosis.

Final diagnosis: Tension pneumothorax

End of case

source:

<http://www.passfirst.com/publication...ccssamples.asp>

Work flow for Ectopic pregnancy
Work flow for pneumonia

Ectopic pregnancy: manage this patient in ER
Work flow: History and PE including rectal and pelvic

Lab:

serum h-CG quantitation

CBC with differential

Blood type and Rh

UA

Intravaginal ultrasound

Management:

IV access

NSS IV

OB/GYN consultation

Laparoscopy

RhGAM

Educate patient on safe sex, drug, alcohol, smoking, exercise, breast examination, pap smearing, vaccine update

Pneumonia in a 6-yr with fever and SOB:

Work flow:

History and PE

Lab:

CBC with differential

UA

Sputum gram staining

Sputum culture

AST/ALT

ABG

Images: CXR

Management:

Admit to ward if kid looks toxic

Pulse oximetry

Oxygen inhalation if SOB is moderate to severe

Penicillin IV

Erythromycin IV

Acetaminophen
Check patient every day
Repeat CBC every 48 hr
D/S erythromycin IV when afebrile for 24 hr
D/C patient on erythromycin
Follow up patient in 1 week with CBC and CXR
Educate patient and parent: nutritious food, hand wash, update vaccination, home safety

you can substitute athroat culture if you like.

do we need to do DRE.....

Acute bact. Prostatitis

The diagnosis of acute bacterial prostatitis (ABP) is based primarily on clinical findings, in association with positive results on urinalysis and urine culture.

So treatment with fluroquin or Bactrim should be started with high clinical suspicion and UA when waiting for urine culture, if wanted.

Care must be taken to avoid vigorous prostatic massage in a patient with suspected ABP to avoid bacteremia and sepsis, this is probably the reason the patient does not want the massage.

***** *****

CCS posted by someone in (march/ april 2003)

1. A 30 year old female patient with a cold and infraorbital headache --maxillary sinusitis.
2. A Latino 30 yr old pharmacist with low grade fever and PPD test positive -- treatment of tuberculosis.
3. A Latino male who is s/p colon carc. resection and admitted to hosp. for treatment of pneumonia developed chest pain - pul.edema/chf.
4. A Latino alcoholic female who is pale and tired; cbc shows hyperseg. neutrophils and increased MCV--folic acid deficiency anemia.
5. A Latino 12 month old child with high fever (40 C) --blood culture showed gram positive cocci in pairs(work up of sepsis)

6. A 25 year old female with H/o DM Type I came to er with n/v loss of appetite ---DKA with urinary tract infection (as UA showed positive nitrites and leukocytes)
7. A young female with burning urination and foul smelling vag discharge--Trich vaginitis.
8. A 60 year old female with headaches and stiffness of joints----Polymyalgia rheumatica.

Sanjana's CCS (mot recent cases APRIL 2003)

are --

1. erosive gastritis
2. cholelithiasis in a sickle cell pt
3. pid
4. uti in a pregnant
5. military recruit
6. idiopathic thrombocytopenic purpura
7. right lower lobe pneumonia
8. pulmonary emboli
9. iron deficiency anaemia in 18 month old baby

CCS posted by billo (march 17th 2003)

1. PE..pt was in the hospital treated for pneumonia 71 yr old...sob
2. 42 yr old female with the breast mass surgeon wants to do surgery send to PMD for other medical disease. she had an upper respiratory infection developed some purpura.....came to u with nose bleed..... her platelet was low but her BT was 20.....
3. Gastritis
4. Obese 16 yr old came for military recruitment
5. Bacteriuria in a pregnant 6 wk
6. 18 month old with loss of appetite.....shows anemia
7. Sickle cell with intermittent abdominal pain
8. vaginal discharge

9. 70 yaer old with abdominal painobstruction series shows rt lower quadrant pneumonia

Someone Named Rao's CCS cases (march 20th)

ccs case.

my ccs were

UTI

ADENOCARCINOMA IN WOMEN IN FIFTIES

DOUDENAL ATRESIA

LEAD POISINING IN 18 MO OLD

PERICARDITIS

PERICARDIAL EFFUSION

DUB

UNCONSCIOUS MAN IN 40 WITH R/R 8

there was also a question set on Gulf war syndrome 4 qustions, mostly how would u responde to his qustions

another Set of recent CCS cases (2nd wk of march 2003)

My ccs cases were

G6PD

CIN III

Iron def anaemia

General check up of a boy with HTN.& obesity.

pulm embolism in colon ca pt

Cystitis,

Cholelithiasis

pnuemonia

Diverticulitis

In real exam ccs cases r really slow,,it takes its own sweat time ,,so practice well so that u dont spend time thinking there

CCS posted by zoella (March 5th 2003)

I was able to manage 6 out of 9 cases well, in the rest I am not sure. In two cases time ran out before I could do something significant. Anyway it's done now and I have left it to God.

Regarding my cases I got:

1. colon cancer
2. ITP
3. 1 child with anemia which I could not get the exact diagnosis.
4. cystitis
5. pulmonary embolism in a cancer patient.
6. sedative poisoning
7. pneumonia
8. obesity
9. cholecystitis

Another CCS posted February 15 2003

- 1) young female with lower abdominal pain, usg showed a ovarian cyst, consulted gynac: said will schedule surgery continue medical management. it was torsion ovarian cyst.
- 2) child 6 yrs old african american comes with pain in right upper quadrant and epigastric region and cough: rt lower lobe pneumonia on chest xray.
- 3) appendicitis: rt lower quadrant pain
- 4) DKA in a 17 year old girl who presented with UTI symptoms. if you guys remember some body had this case and it was posted here.
- 5) acute bacterial prostatitis:
trucker male with low back pain and perineal pain and discomfort. asked for prostatic massage and culture of secretion: came positive for ecoli. treat bactrim.
- 6) alcoholic trauma patient with dizziness and abdominal left upper quadrant discomfort
rib fracture: diagnosis: splenic hematoma
- 7) young female with vaginal discharge: acute PID
- 8) 53 year old female with pain in abd: sigmoid diverticulitis with abscess around the sigmoid.

9) pulmonary embolism with ccf : elderly hypertensive male with shortness of breath and history of long airtravel .

Some one named Ji's CCS january 2003

CF,
angina,
dematia,
DKA,
newly Dxed DM type-II,
50yo F regulur physical.
duodunal ulcer

Someone Named anonymous's CCS (posted jan 2003)

- 1- polycystic kidney disease: 50 y.o.w.m with PMH of HTN presented with mental problem (I dont remmber). I did UA, sma7 and then Echo which was diagnostic. hemodialysis..
- 2- angioderma: shellfish with edema in face and lips and SOB. epineph and o2...discharge.
- 3- pneumonia (60 y.o.w with right upper abdominal pain had URI three days ago): CXR and erythromycin only!!!!
- 4 acute diverticulitis (50 y.o.AA.w. with left lower abdominal pain, no Occult blood), exam abdomen and rectum only!, showed mass, KUB: dilated loops. metro and cefotaxim and sendf home on diet.
- 5- chf with sob, R/O MI and supportive care and add HCTZ for his regimen which included aspirin and ACEI.
- 6-dm II (tricky). prostate problem in a 60 y.o.m presented with thirst and improved urinary problems.. glucose only...350.. workup diet and other junk staff and send home and F/U...The only thing happen in this case that he was still thirsty which i called him in and hydrate him..and then all massges were ok.
- 7- sickle cell anemia with chest pain. supportive ICU and hydroxyurea.
- 8- HTN, stage I: AA boy wants to be involved in football teem HTN repeat and repeat....then diet, smoke alcohol, drugs.... improves over 3 months...and happy!!!!
- 9- pid classic easy.

I knew the dx right away and I ordered only related tests. no patient had any complain. All massages were positive. I did the best cost effective approach.
If I pass I would tell you what to do.
good luck for all of you. It is really a good forum, three of my cases have been posted here before exactly the same story which helped a lot.

Anant's CCS (december 2002)

young woman-ac asthma,gets better with Iv steroids and albuterol

2-kid with icterus,g6PD def

3-woman with no complaint except fatigue-post infectious thyroiditis(T4 high,TSH normal)propranolol took care of the symptoms

4-male middle aged-tired(like us all)we can have the luxury of saying we are depressed,he was,give SSRI

5-overweight female(lightly)...routine visit,tired pees a lot at night,only in the US they dont think its BM..give oral hypoglycemic she wont get up at night to flush

6-trip to Australia..leg swolllen.I wanted a picture post card but there was this little problem of PE sent her into cyber space with elevated bleeding count..last i heard of her she was doing well.I will do well too if you pay me a trip to Australia.

warfarin etc after usual ultrasound(the damned leg is swollen) and PQ to tell higher-souls that you know it exists...CCS have nothing-well only a little- to do with what we do in real life(exam wise){p<.ooo5)

7-I take a break

Another set of CCS posted in december 2002

1-Acute cholecystitis

2-ITP

3-UGI Bleeding

4-DKA

5-Bacterial Vaginosis

6-Hypothyroidism + Iron deficiency anemia

7-Alcohol Abuse

8-Pneumonia

9-foreign body aspiration(peanut)

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#28

Old 09-26-2003, 12:08 AM

Anonymous Anonymous is offline

Unregistered Guest

Join Date: Jan 2003

Posts: 0

Vetan's CCS
All CCS in one page
March 2 2003 at 5:23 PM

I compiled all the cases in one page for easy printability.. Good luck

Acute Gout Attack January 16 2003 at 11:51 AM Ferritin (Login ferritin) from IP address 12.234.186.166

hey vetan, i am not good at this but I will try. Please feel free to delete this if it does not fit in here. Step 1: keep foot elevated Stool guaiac. Labs: cbc, sma7, Uric acid, UA with microsynovial fluid :for light polarising micrograph. C&S, Gram stain, glucose, protein, cell count. X-RAY JOINT. 24 hour urine for UA Diet: low purine Medication: Motrin PO or Indomethacin Po for 2 days, then hypouricemic therapy: Probenicid increase until UA level falls below 6.5. Allopurinol , after attack. symptomatic: Ranitidine bid. Meperidine or Vicodine

CCS- Splenic Rupture February 26 2003 at 4:16 PM vetan (no login) from IP address 65.66.15.248

diagnosis : splenic hematoma HPI 23 y/o male after MVA. ABCPE focus Labs: serum glucose and rapid bedside glucose determination CBC serum chemistries amylase lipase sucoagulation studies blood type and match abg, blood ethanol urine drug screens. Bedside u/s, DPL (for unstable), CT (for stable) and emergent surgeon consult. Chest x-ray, supine & erect abdomen x-ray Abdominal sono(er) or abdominal CT Vital, Cardiac, and BP monitoring on bed side. Foley catheter and Urine output check. Ringer's lactate sol I.V before results from Lab. Transfer to ICU if patient is not stable. posted by raavii02 good work up I would add surgical consult for repair also prefer NS as IVF rather than LR because in case he develops rhabdo. (MVA) NS is fluid of choice.

CCS- AMI December 23 2002 at 7:17 PM vetan (no login) from IP address 66.141.67.118

History of present illness: A 45 yrs old patient brought to the e.r. with excruciating stabbing pain on his chest and inner arm for 20 min . the pt. has no history of previous attack but is a hypertensive candidate with BP 190/ 96 when last taken. pt. is conscious but looks anxious. vital sign; temp-97, pulse-86/min, resp. rate-33/min, Step I : Emergent management: A, B, C, D- O2, IV access, Step II : Physical Examination Focus PE Heent/Neck, Chest/Lungs, Heart/Cv, Abdomen, Extremities Step III : Diagnostic Investigations: EKG, CXR, CK-mb, Troponin-I, CBC, Chem -7, continues cardiac monitoring Treatment: 1. NTG 0.4mg sl 2. Aspirin 3. Morphine if patient is in pain 4. ACEI (ramipril) 5. Depending on time since onset consider t-PA if not contraindicated or cardiac cat. 6. Consider nitroglycerin drip. Other antihypertensive you may consider is labetalol or

nipride(more severe cases).Step IV: Decision about changing patients location 1. Admit the patient to CCU, if patient is symptomatic send to ward.2. repeat cardiac markers 3. discountinue cardiac monitor after 24 hours if patient is stable4. When patient is stable consider submaximal exercise test5. All patient with MI should go home on B-blockers6. check lipid profile7. consult on healthy life style prior to discharge8. make appointment to see him in about a weekSTEP V: Educate patient family.console patient, stop smoking, diet, excercise.STEP VI: Final Diagnosis.AMI

CCS-PIDFebruary 8 2003 at 6:14 AM vetan (no login)from IP address 65.66.18.199

HPI25 Year old WF c/o lower abd pain.PE:Pregnancy testCBCChem7Endocervical gram stain-for gram-negative intracellular diplococciEndocervical culture-for gonorrheaEndocervical culture or antigen test-for chlamydiaTREATMENT:Outpatient, normallyHospitalization recommended in the following situations:Uncertain diagnosisSurgical emergencies cannot be excluded, e.g., appendicitisSuspected pelvic abscessPregnancyAdolescent patient with uncertain compliance with therapySevere illnessCannot tolerate outpatient regimenFailed to respond to outpatient therapyClinical follow-up within 72 hours of starting antibiotics cannot be arrangedHIV-infectedGENERAL MEASURES Avoidance of sex until treatment is completedInsure that sex partners are referred for appropriate evaluation and treatment. Partners should be treated, irrespective of evaluation, with regimens effective against chlamydia and gonorrhea.SURGICAL MEASURES Reserved for failures of medical treatment and for suspected ruptured adnexal abscess with resulting acute surgical abdomenInpatient treatment; Cefoxitin IV cefotetan IV (or other cephalosporins such as ceftizoxime, cefotaxime, and ceftriaxone) plus doxycycline orally or IV Therapy for 24 hours after clinical improvement and doxycycline continued after discharge for a total of 10-14 daysClindamycin plus gentamicin loading dose IV or IM Therapy for 24 hours after clinical improvement with doxycycline after discharge as aboveOutpatient treatmentceftriaxone plus doxycycline orally for 10-14 daysOfloxacin orally for 14 days plus either clindamycin orally or metronidazole PATIENT MONITORING Close observation of clinical status, in particular for fever, symptoms, level of peritonitis, white cell countsafe sex practices education-particularly for those who have had an episode of PID

CCS- DepressionFebruary 21 2003 at 5:44 PM vetan (no login)from IP address 65.66.18.2

HPI:40 years old executive man comes to the office with chief complaint of headache.Later he gives history of financial problem and starts crying.First pay attention to history for alcohol or recent drug use.you should check HPI to see when these headaches started ,is it reoccurrent?, is patient's energy level has change recently, etc..R/O medical cause.PE:completeLabs:CBC- possibly WNLChem-7UA- WNLAlcohol and Urine Drug screening- need to rule out drug use.TSH- probably WNL- rule out thyroid problem.if all above normal. depression index- response to 20 question indicates depression.start antidepressant- if patient is obese use celexa otherwise any ssri would be

fine.schd. psychotherapy (with psychiatrist) to augment medication.schd. patient for follow-up in 3 weeks.

CCS- Spleen ruptureFebruary 9 2003 at 7:38 AM vetan (no login)from IP address 65.66.15.120

HPI23 y/o male after MVA.ABCPE;focusLabs:serum glucose and rapid bedside glucose determination CBCserum chemistriesamylaselftsuacoagulation studiesblood type and matchabg, blood ethanolurine drug screens.Bedside u/s, DPL(for unstable), CT(for stable) and emergent surgeon consult.Chest x-ray, supine & erect abdomen x-rayAbdominal sono(er) or abdominal CTVital, Cardiac, and BP monitoring on bed side.Foley catheter and Urine output check.Ringer's lactate sol I.V before results from Lab.Transfer to ICU if patient is not stable.

CCS- chron's diseaseFebruary 8 2003 at 9:58 AM vetan (Login run24)Forum Ownerfrom IP address 66.141.67.67

HPI28 y/o female comes to office c/o diarrhea for several days.PE:Complete- Labs:CBC-check for leukocytosisChem7Guiac - positive for bloodstool culture- WNLstool for ova and parasite- WNLColonoscopy- biopsy- inflammatory process consistence with chron's diseaseTreatment:mesalamineantidiarrhealreevaluate patient in couple days- patient diarrhea has improved. Patient is feeling better.see patient in 2 weeksdiagnosis:chron's disease

CCS- Sickel-cell crisis(ooffice)February 8 2003 at 6:00 AM vetan (no login)from IP address 65.66.18.199

HPI6 Year old AAM was brought to your office because of pain he has a history of sickle cell disease.PE:Complete PELabs:CBCChem 7Type and crossTreatmentulse oxo2Iv Fluidmorphineexchange blood transfusion- if patient doesn't improve or Hgb is low.floic acidimmunization: H.influenzae B and pneumoccal vaccinesAminocaproic acid for hematuriaIf recurrent CVA, chronic transfusion programEducationCounsel

CCS- Sq. Lung cancerFebruary 8 2003 at 3:05 PM vetan (Login run24)Forum Ownerfrom IP address 66.141.67.229

HPI67 y/o female with 30 years history of smoking come to office c/o cough.PE:completeLabs:Pluse oxo2CBCChem 7CXR- mass on left upper lobebiopsy- sq. cell carcinomasurgical and onconlogy consultdiagnosis:sq. cell carcinomayou may ask how I am going to treat this patient. You probably won't have time to do any kind of treatment because when you make the diagnose case will end.

CCS- ASTHMA December 23 2002 at 7:20 PM vetan vetan (no login) from IP address 66.141.67.118

History of present illness: 5yo child with acute asthmatic attack
Note vital signs: BP, Pulse, Resp. Rate, Temp.
Step I : Emergent management: A, B, C, D- O₂, broncodilators MDI or nebulizer, depending on severity consider systemic corticosteroids.
Step II : Physical Examination General appearance, HEENT/Neck, Chest/Lung, Heart/CV
Step III : Diagnostic Investigations: 1. O₂ sat. 2. PEF 3. CBC 4. Chem 75. CXR 6. ABG- should be considered in severe distress or when FEV₁ < 30% of predicted values after initial treatment.
Treatment: 1. O₂. 2. Beta 2 agonist with MDI or Nebulizer every 20 mins 3. methylprednisolone IV q6h for first 24-48 hours then inhaled steroids
Step IV: Decision about changing patients location Discharge home if symptoms resolve quickly or FEV₁ is greater than 70% of predicted or personal best.
Recommendation for hospitalization 1. response to treatment is poor 2. recent hospitalization for asthma 3. failure of aggressive outpatient management 4. previous life-threatening attack 5. If PEF or FEV₁ is less than 50% 6. arterial carbon dioxide tension is greater than 42 7. If patient is confused or drowsy 8. If no easy access to ER
If patient is discharged need to return to office within 5-7 days for follow up.
Step V: Educate patient and family: Instruct patient/family to avoid factors that aggravate patients disease. Instruct on proper use of MDI
STEP VI: Final Diagnosis. Acute Asthma Attack

CCS- Nortryptiline Toxicity February 8 2003 at 8:14 AM vetan (Login run24) Forum Owner from IP address 65.66.18.199

HPI 27 y/o female was found unconscious with a bottle of pill. ensure ABCPE: HEENT/Neck, skin, CV, Lung, ABDlabs: CBC Chem 13 Puls ox EKG ABG drug level
Treatment: Gastric lavage Activated charcoal with intermittent gastric suctioning Induce alkalinisation with NaHCO₃ to maintain pH of 7.45 to 7.55
If he is intubated hyperventilate to a PCO₂ < 35 and > 25 mmHg
Foley If ECG normal and patient is asymptomatic, observe for 6 hrs in ER otherwise admit to ICU
After Admission ECG should be normal for 24 hrs to discharge for psychiatric disposition

CCS- Sick cell crisis (office)

HPI

6 Year old AAM was brought to your office because of pain he has a history of sickle cell disease.

PE:

Complete PE

labs:

Blood smear

Hb electrophoresis

BUN & Cr

Lfts

Electrolytes
Xay skeletal

Tx
pulse ox
o2
Iv Fluid
morphine
type and cross
exchange blood transfusion
hydroxyurea
Penicillin V 125 mg bid up to age 3; then 250 mg bid up to age 5
folic acid
immunization: H.influenzae B and pneumoccal vaccines
Aminocaproic acid for hematuria
If recurrent CVA, chronic transfusion program
Bone marrow transplation

Eduation
Counsel

CCS- COMMUNITY ACQUIRED PNEUMONIA February 8 2003 at 6:36 AM vetan (no login) from IP address 65.66.18.199

HPI 64 Year old WF comes to your office c/o several days of cough. PE: complete Labs: CBC - leukocytosis with an immature shift on differential Chem 7- hyponatremia (SIADH) ABG - hypoxemia sputum culture and sensitivity IMAGING Chest roentgenogram -(with lateral decubitus views if pleural effusion present) Lobar or segmental consolidation (air bronchogram) Bronchopneumonia Interstitial infiltrate Pleural effusion (free-flowing or loculated) TREATMENT: Community-acquired outpatient for mild case, inpatient for moderate to severe case such as hypoxemia, altered mental status, hypotension, significant co-morbid illness, and age extremes. Empiric antimicrobial therapy oxygen - for patients with cyanosis, hypoxia, dyspnea, circulatory disturbances or delirium Analgesia- for pain Electrolyte correction Initial therapy community-acquired pneumonia requiring hospitalization a specific cephalosporin (cefotaxime or ceftriaxone) or cefuroxime) or ampicillin-sulbactam plus macrolide or a pneumococcal-active fluoroquinolone alone PATIENT MONITORING If outpatient therapy, daily assessment of the patient's progress, and reassessment of therapy if clinical worsening or no improvement in 48-72 hours Reduce risk factors where possible (quit smoking) Annual influenza vaccine for high risk individuals

CCS- APKD February 8 2003 at 6:22 AM vetan vetan (no login) from IP address 65.66.18.199

HPI 32 y/o male for routine check up. PE: complete LABORATORY CBC- Hematocrit - elevated in 5% of cases Urinalysis - may have hematuria and mild proteinuria Chem 7- Serum creatinine may be elevated Kidney U/S - stones usually calcium oxalate IMAGING Ultrasonography: > 5 cysts in the renal cortex or medulla of each kidney, in children, 2 or more cysts in either kidney CT scan- more sensitive 85% of patients can be detected by age 25 TREATMENT: Outpatient- except for complicating emergencies (infected cysts require 2 weeks IV antibiotics then long-term oral antibiotics) GENERAL MEASURES bed rest and analgesics for Pain ACTIVITY Avoid contact activities that may damage enlarged organs. DIET Low protein diet may retard progression of renal disease. PATIENT EDUCATION Genetic counseling is critical Avoidance of nephrotoxic drugs Treatment: No drug therapy available for polycystic kidney disease Hypertension - ACE inhibitors; avoid diuretics (possible adverse effects with cyst formation)

CCS- Cystic Fibrosis February 7 2003 at 5:40 PM vetan (Login run 24) Forum Owner from IP address 65.66.14.226

HPI 7 month old child with foul smelling stools and recurrent episodes of bronchiolitis (cystic fibrosis) PE: General appearance, Heent/Neck, skin, chest/lung, heart/CV, Abdomen Labs: CBC Chem-13 sweating test (Cl > 60 mEq/dl dgn) CXR Pulmonary function test ABG's Sputum culture & sensitivities of cultured organisms Treatment: Antibiotics if signs of infection - iv ceftriaxone + gentamycin for pulm. infections (I/V Semi-synthetic Penicillin or Cephalosporin with Anti pseudomona activity- Ceftazidime) Albuterol inh- Bronchodilators Chest physiotherapy: postural drainage + percussion breathing exercise vigorous coughing exercise program Pain medication if needed Nutritional support: high calorie diet, oral pancreatic enzymes, vitamin A, D, E and K supplement.

CCS- Child Abuse February 4 2003 at 10:12 PM vetan (no login) from IP address 66.141.67.163

HPI 4 y/o boy brought to ER for evaluation by mom. ORDER SHEET Skeletal Survey Urinalysis CBC with differential PT/PTT bleeding time ophthalmologic consult (?) for retinal hemorrhages CXR Electrolytes, serum Creatinine, Serum Blood Urea Nitrogen Bilirubin, Serum Total and Direct If sexual abuse considered, cultures of mouth, rectum /vag, urethra, VDRL ADMIT to WARD Diet: Full regular diet Social Worker Consult Child's Protective Agency report to local authorities (state protection agency) DISCHARGE: When the child gains his health, assure his safety and the hospital knows his destination.

CCS- ATN February 4 2003 at 6:11 PM vetan (no login) from IP address 65.66.18.246

HPI patient after MVA had developed decreased urine output. O2 pulse O2 if need to Labs: CBC Chem 7 UA CPK Treatment: 1. IVF with NS 2. Diuresis with Lasix 3. Sodium bicarb. Patient improves.

CCS- ovarian cancer February 4 2003 at 6:06 PM vetan (no login) from IP address 65.66.18.246

C/cold lady with abdominal mass, ascites, stable vitals or mild resp distress due to pleural effusion. Labs: cbc, sma7, ua, esr, lft, fob, CXR abdominal u/s if mass positive ct for metastasis. laproscopic biopsy of the mass- adeno/begin if adeno- debulking. paracentesis if severe symptomatic. lateral decubitus >10mm do thoracentesis if u her cbc and counsel

CCS- Premature labor (Office) February 2 2003 at 5:57 PM vetan (no login) from IP address 65.66.12.222

26 y/o 32 weeks gestation presented with two 30 sec contractions in 10 minutes cervix 3 cm dilated. Effacement 70%. Transfer to Ward. Labs: CBC with differential. U/S for fetal size, position, placental location. Amniocentesis for equivocal fetal maturity. Urinalysis, urine culture (urine obtained by catheter). Electrolytes, serum glucose. Treatment: bed rest, hydration. If this fails tocolysis with mag. Sulfate/ ritodrine. Glucocorticoids for lung maturity. Note- (contraindications for tocolysis: ruptured membranes, cervical dilation >4 cm, effacement >80%, fetal death, fetal distress, IU infection, polyhydramnios, IUGR, erythroblastosis, severe maternal hypertension, maternal pulmonary, cardiac disorders, abruptio placenta, placenta previa).

CCS- Trichomonas vaginitis (Office) February 2 2003 at 5:50 PM vetan (no login) from IP address 65.66.12.222

24 y/o female complaining vaginal discharge and itching. Labs: CBC, Chem 7, wet mount (saline and KOH) test to identify the organism. DX of trichomonas: pruritis, fishy odor, gray or yellow-green discharge, PH >4.5. Treatment: metronidazole 2gm x1 and treat partner. At discharge consult pt. For safe sex.

CCS- Colon cancer December 23 2002 at 7:27 PM vetan (no login) from IP address 66.141.67.118

History of present illness: 60 year old male presenting to office for regular checkup. VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F) Allergy: NK A Step I : Emergent management: A, B, C, D-Not needed Step II : Physical Examination Complete- General appearance, Skin, Lymph Nodes, HEENT/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro. Step III : Diagnostic Investigations: 1. CBC 2. UA 3. Chem-124. Lipid profile 5. Because of his age he needs Guaiac stool, If positive followed by colonoscopy. result will show evidence of colon cancer. 6. Liver function tests, Chest x-ray to look for metastatic disease. Step IV: Decision about changing patient's location 1. After initial workup admit

patient for elective surgery.2. Surgery consult. Get type and cross, CBC, Chem 12, EKG, CXR, PT, PTT, LFT, inform consent, NPO, and CEA level prior to surgery.STEP V: Educate patient and family:After surgery patient should be evaluated every 3-6 months for 3-5 yrs with history, physical examination, fecal occult blood testing, liver function tests, and CEA determinations. Clonoscopy is performed within 6-12 months after operation to look for evidence of recurrence and then every 3-5 years.Step VI: Final Diagnosis:Colon Cancer
turners syndromeJanuary 16 2003 at 5:19 AM kim kim (Login mercysaba)from IP address 205.188.208.166

mother brings a 16 yr old girl with no menstruationor16 yr old for normal physical exam, menstruating1.no need of abc as it is a office visit for routine chech up2.physical-complete,you will get the webbed neck,widely spaced nipple, ahort stature, lack of breast development3.cbcsma 7uacxr- pulmonary hypoplasiaekg- coa, bp different in armsecho-coa, bicuspid aortic valveu/s abd- horeshoe kindneykaryotype- xo4.reassurancef/u in 2 weeks in officeif confirmed- < 12 yrs- growth hormone im injection+striods<12 yrs-e+p (hrt)counsilconsult cardioldy/urology/gyn(for streak ovary removal)f/u in 4 weeks

CCS-Alzheimer's Dementia.January 16 2003 at 10:28 PM Auguste Duplan Auguste Duplan (Login duplana)from IP address 24.191.17.124

CCS-Alzheimer's Dementia.Affects 15% of people over age 65. Occurs in Down's syndrome pts at younger ages (30-40). Gradually progressive, neurofibrillary tangles.Alzheimer's Disease: senile degenerative dementia (50%-90 of dementia pts) - Loss of cortical tissue (cerebral atrophy) with increased senile plaques. Criteria for the clinical diagnosis of probable Alzheimer's disease * Dementia established by clinical examination and documented by the Mini-Mental State Examination, include: Blessed Dementia Scale, or some similar examination and confirmed by neuropsychologic tests. Deficits in two or more areas of cognition. Progressive worsening of memory and other cognitive functions No disturbance of consciousness * Onset between ages 40 and 90, most often after age 65 * Absence of systemic disorders or other brain diseases that could account for the progressive deficits in memory cognition Lab. Orders: CBC, Lytes, TFTs, PRP all normal. UA toxicology -ve. CT: Evidence of cerebral atrophy with progression documented by serial observation MRI shows changes highly suggestive of Alzheimers - tangled spaghetti patches. Certain dx: not till autopsy - on PM see structural changes, abnormal proteins in brain biopsy. See shrinkage < neurons in cognitive areas of brain. Early Signs: subtle loss of memory. Person neglect, ADL. Gradual loss continues. Loss of communication skills. Later: ultimate loss of short and long term memory. Normal life span. May have good physical health. Med Intervention: No real medical therapy. Nursing support primary. Med Rx: Donepezil (Aricept) 5-10 mg tablet /dayTacrine (Cognex) Not a cure. Does not appear to stop progression as was hoped. Acts to increase amount of acetylcholine in brain to improve memory. Helps to improve in a minority of patients.Side effects: Hepatic failure, GI, abd. Pain, skin rash. Rivastigmine tartrate (Exelon) 6-12 mg cap/day Premarin for ladies Multivitamins 1 tb qd po Aspirin For

vascular dementia Other supportive med Rx therapy for agitation: antidepressants, antipsychotic, sleeping aids. Nursing focus: Safety, Help maintain function as long as possible, Care for caregiver. Continuing Care: Medicare doesn't cover custodial long term. Must become impoverished to go on medicaid. Few families able to cope with entire trajectory of the illness. Nursing home care essential for some. As for Alzheimer: Remember, on the exam, when ever you counsel it takes 5 minutes for it. - Social services consult- counsel, no driving- counsel, advance living will- reassure patient/family- counsel medical alert bracelet

CCS- Hypothyroidism (office visit)

History of present illness:

A 55 year old black woman with fatigue, weight gain, loss of lateral third of eyebrow, obese and other nonspecific signs/symptoms presented to office.

Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)

Allergy: NKA

Step I: Emergent management:

A, B, C, D- Not needed.

Step II : Physical Examination

Physical Examination

General appearance, HEET/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Neuro.

Step III : Diagnostic Investigations:

CBC

TSH (don't jump right away to whole thyroid function test as tsh is cost effective compared to whole thyroid pannel....if tsh comes abnormal then do whole thyroid pannel).

Thyroid Panel

Chem 12

EKG – To rule out Cardiac disease. Patient with cardiac diseases should be started on low dose (25 Mcg) and monitored closely.

lipid profile- patient is obese and at risk for CHD.

Treatment:

levothyroxine – Plasma TSH should be measured 2-3 months after initiation of therapy.

Step IV: Decision about changing patients location

Move patient home with follow-up appointment in 4 weeks.

Stool guiac as part of yearly exam in this old pt.

pap smear is due or have not been done.

Step V: Educate patient and family:

Advised patient on low cholesterol, low fat, and low na (high bp) diet, exercise program, etc.

when 5min left screening warning, ordered repeat TSH in 4 weeks (to make sure, it is going down).

Step VI: Final Diagnosis:

Final Diagnosis: hypothyroidism

67 y o lady with HX of fatigue (Dyspeptic symptoms with weight loss)

VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)

Allergy: NKA

CCS-Gastric Cancer

January 13 2003 at 6:53 PM

Step I: Emergent management:

A, B, C, D-Not needed

Step II: Physical Examination

Complete- General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro

Step III: Diagnostic Investigations:

1. CBC (Iron Deficiency Anemia)

2. Peripheral Smear

3. RI

4. TSH

5. Chem-7

4. Occult blood test stool (+++): because of her age she needs to go directly to:

Step IV: Decision about changing patient's location

Transfer Patient to Medical Ward (Colonoscopy is a hospital procedure)

1. Emergent Lower colonoscopy and work based on the result (here will be -)

2. Emergent upper endoscopy with cytologic brushing and biopsies (adeno cell Ca)

3. LFT (metastasis)

4. Abdominal CT for identifying distant metastases.

5. Pre op workup such as blood type/cross match, CXR, EKG, PT, PTT, BT, start iron, Zantac.

6. Consult Surgery/Oncology/: Message surgery will be available shortly

DO interval/brief physical exam

STEP V: Provide counseling from the list (Pt/family/advance directive)

Case will end here

Step VI: Final Diagnosis:

Gastric Cancer

CCS-Folic Deficiency Anemia (Office)January 13 2003 at 9:38 PM vetan (no login)from IP address 65.66.15.240

History of present illness:A 52 year old man come to office complaining fatigue. He has a history of drinking.Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F) Allergy: NKAStep I : Emergent management: A, B, C, D- Not needed.Step II : Physical Examination General appearance, HEET/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Rectal, Neuro.Step III : Diagnostic Investigations: CBC/Diff (MCV > 110), Leukopenia, thrombocytopenia.Peripheral Smear- anisocytosis, poikilocytosis and macro-ovalocytes, hypersegmented neutrophils.RITSH (Ultrasensitive)Occult blood test (-)Chem 7LFT-LDH and bilirubin may be elevatedLipid profile- if patient has risk factorOrder Folic acid (low/ B 12 level)- serum B12 and RBC folate levels. if level equivocal do Homocystine level.Initial Treatment: Start Folic Acid ContinuousMultivitamin dailyMessage: pt is feeling betterDo Interval History and physical examStep IV: Decision about changing patients location Move patient homeSchedule 1 weekRefer for Substance abuse evaluation Step V: Educate patient and family:Quit AlcoholQuit SmokingExercise programAdvance directive Case will end here Step VI: Final Diagnosis: Folic Deficiency Anemia

CCS-Erosive GastritisJanuary 13 2003 at 6:39 PM SAM (no login)from IP address 12.77.88.219

History of present illness:

55 yr old African American pt with history of Arthritis/chronic aspirin therapy presented to office with c/o fatigue

VITAL SIGNS- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)
Allergy: NKA

Step I: Emergent management:
A, B, C, D-Not needed

Step II: Physical Examination
Complete- General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III: Diagnostic Investigations:
1. CBC (Normocytic Normochromic Anemia)
2. TSH
3. Chem-12

4. Occult blood test stool (+++): because of his age he needs to go directly to:
5. Colonoscopy (-) followed by endoscopy (++) for gastric ulcer, no evidence of malignancy)
6. DC ASA
7. Start Acetaminophen, Zantac
8. from the counseling list: Quiet smoking
9. from the counseling list Quiet alcohol
10. Advanced directive

Step IV: Decision about changing patient's location

Home with 2 weeks follow up
 Pt comes feeling better
 Do Interval history and physical exam
 Repeat CBC only

STEP V: Educate patient and family: and case will end here

Step VI: Final Diagnosis:
 Erosive Gastritis

CCS- Transient Ischemic Attack (ED)January 11 2003 at 9:36 AM vetan (no login)from IP address 65.66.17.115

Transient Ischemic Attack (ED)History of present illness:Patient 54 years old with a hx of Hypertension, hypercholesterolemia, smoking and DM . wife brought her husband because he dropped a plate on the floor & he was unable to understand what she was saying, she asked him to write, he wrote couple of sentences that didn't make any sense, episode lasted few hrs. she brought her husband to ER.Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F) Allergy: NKADX:TIA Thrombotic or embolic strokeSubdural hematomaSeizureStep I : Emergent management: A, B, C, D- Not needed.Step II : Physical Examination General appearance, HEET/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Neuro.Physical: BP 170/98 P 100A loud bruit was auscultated over left carotid, no murmurs, rubs or bruits were heard over pericardium. neuro was nonfocal.Step III : Diagnostic Investigations: Initial Test:1. CBC2. Chem-63. CT- (remember CT takes about 2hrs, is this patient stable enough to send to CT(YES), are there any other tests(blood tests) you should do before you send him to CT. Think reason before you do a test, do not write all possible tests you could do . "Save cost, do less invasive tests, save time, be focused on that particular case, effective decisions. If CT questionable, MRI is more accurate. Why do you do a CT in this case? To rule out hemorrhage! Will the hemorrhage show in CT?, in which time phrase?Hemorrhage will show within 24 hrs, but infarcts will take few days.Why do you want to exclude hemorrhage?There is a carotids stenosis,neurological deficit we want to think, to give anticoagulation to this patient, if there is a hemorrhage he will bleed more with anti

coagulation! Test results: after 2 hrs, remember patient is in YOUR care for TWO hrs now! CT: NEGATIVE Diagnosis: Considering HX, physical, & the test you have done: this patient has 'expressive aphasia left temp, because the deficit lasted only few hrs it is TIA. TIA by definition, deficit lasting <24hrs. CT scan most of the time will not show any deficits in first 24 hrs. There is a bruit on carotis, might represent a plaque that sent a small embolus to the brain. Step IV: Decision about changing patients location Admit to ward Further Diagnostic Plan: 4. Carotis doppler 5. Angiography 6. 24hrs Holter 7. Echocardiogram Results: >70% stenosis 77% stenosis no arrhythmia no valvular disease, no evidence of Thrombus Treatment Plan: 1. Antiplatelet-Aspirin 2. Heparin 3. Vascular surgent consult for elective CEA- A Multidisciplinary Consensus Statement from the American Heart Association concluded that carotid endarterectomy is of proven benefit for symptomatic patients, including those with single or multiple TIAs or those who have suffered a mild stroke within a 6-month interval, who have stenosis of greater than 70% with a surgical risk of less than 6%. 100% stenosis ; NO CEA-causes hyperperfusion Step V: Educate patient and family: Stop smoking Better BP control-(exercise, diet, Pharma.....) DM control(exercise, diet, pharma) Continue aspirin or plavix Step VI: Final Diagnosis: Transit Ischemic Attack.

CCS- Narcotic Overdose (ED) January 11 2003 at 8:53 AM vetan (no login) from IP address 65.66.17.115

History of present illness: 25-yr- lady brought in unconscious with bradycardia, hypotensive and pinpoint pupils classic case of narcotic overdose. Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F) Allergy: NK A Step I : Emergent management: A, B, C, DA: Airway suction, Pulse Ox Q 1 hr or continuous monitoring, O2 B: Endotracheal intubation in O2 sat. does not improve with O2 nasal or PaO2 <55, or PCO2 >50, C: IV access (KVO), cardiac monitor, catheter Foley, finger stick glucose D: Drugs: thiamine, dextrose 50% and naloxone-all are IV bolus one time dose Step II : Physical Examination General appearance, HEET/Neck, Heart/CV, Lymph Nodes, Skin, Chest/Lung, Abdomen, Extremities, Neuro. Step III : Diagnostic Investigations: 1. B-HCG 2. ABG 3. CBC 4. Chem 13 5. PTT/PT 6. EKG 12 lead 7. CXR portable 8. UA, UDS, BAL, Barbiturate level(level > 80-100 causes coma), blood aspirin and blood acetaminophen level. Initial Treatment: Order gastric lavage gets the result (which revealed pills fragments) Order Activated Charcoal Started naloxone drip, if evidence or BZD use, give flumazenil. Alkalinisation of the urine is useful with phenobarbital and barbitol overdose Interval HX on brief physical Step IV: Decision about changing patients location Move patient to ICU Check lytes again DC Intubation if patient has improved DC NG Tube Cont cardiac/ox pulse 24 hrs DC Naloxon Step V: Educate patient and family: Psych consult (result will tell, the hx consistent with suicidal attempt) Order suicide precautions Move pt to ward Basically the Psych ward DC IV line Start regular diet Start patient on Antidepressant Step VI: Final Diagnosis: Narcotic overdose

CCS- Acute Pericarditis (ED Setting) January 3 2003 at 8:13 PM vetan (no login) from IP address 65.66.12.236

History of present illness: 45 year-old lady with substernal chest pain, Hx of previous URI
Orders: O2, IV Line (KVO) Cardiac monitoring, pulse monitoring
Physical Examination General Appearance, HEENT/Neck, Extremities, Chest/Lung,
Heart/CV
Diagnostic Investigations: O2 saturation EKG (ST elevation in all leads) Cardiac enzymes, Troponin I (-) Chem 7 (WNL) CXR Portable (WNL) ABG (WNL) CBC
Treatment: Start ASA continuous (can use indomethacin or in severe cases corticosteroids)
Next order in the ED ECHO (result was some fluid, but not severe)
Next DC O2, Monitor
Next Reassurance Educate patient and family DC to home and F/U office.
Final Diagnosis: Acute Pericarditis

CCS- Solitary Pulmonary Nodule (office) January 2 2003 at 9:13 PM vetan (no login) from IP address 65.70.118.167

Solitary Pulmonary Nodule (office) History of present illness: 55 year-old smoker male with history of blood in the sputum
Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)
Allergy: NK
Step I : Emergent management: A, B, C, D- Not needed.
Step II : Physical Examination
Complete Physical Examination
Step III : Diagnostic Investigations: CBC Chem 7
Sputum: Gram stain. AFB, C&S PPD CXR PA/L Nodule in the R U Q Lung
Spirometry EKG Pulse OX
Next order in the office Chest CT (it will give you the size of the nodule 2.5 mg)
Bronchoscopy and biopsy (result was SC Ca)
Next consult surgery
Order now LFT, Head Ct, Blood type/cross match
Step IV: Educate patient and family: Stop smoking
Next educate patient and family
Step V: Final Diagnosis: Solitary Pulmonary Nodule
Case end here

CCS- Active Tuberculosis December 24 2002 at 12:04 PM vetan (no login) from IP address 66.141.65.214

TB (Sudan immigrant Case): office History of present illness: 55 yr old immigrant psychiatrist came in with classical symptoms of pulmonary TB
Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F)
Allergy: NK
Step I : Emergent management: A, B, C, D- Not needed
Step II : Complete Physical Examination
Step III : Diagnostic Investigations: Order the following: 1. CBC 2. PPD 3. Chem. 12, LFT 4. UA 5. Sputum smears AFB 6. Sputum TB culture and PCR test (result will be ready by PCR within 24 hrs)
Now get the results of (AFB was negative. PCR came positive after couple days).
Order CXR and the result was (upper apical infiltrate/cavity).
Now you need to decide to admit or treat as an outpatient (remember hospitalization for the initial therapy of TB is not necessary in most patients)
Step IV: Decision about changing patients' location
Treatment plan: 1. Notify the health dept. 2. Start treatment with 4 drug regimen: INH, Rifampin, Pyrazinamide, and either Ethambutol or Streptomycin 3. Weekly sputum smear and cultures and then monthly once they test negative. 4. Ordered f/u appt with f/u sputum study. 5. influenza/pneumonia

vaccine, multivitamin6. HIV Test in all pts with TBStep V: Educate patient and family: Counseling and Education. Step VI: Final Diagnosis: Active Tuberculosis

CCS- G6PDDecember 23 2002 at 7:29 PM vetan vetan (no login)from IP address 66.141.67.118

History of present illness:young boy present with pallor, jaundice and splenomegaly. Recent history of URI treat with Bactrim(sulfa).First note vital signs – make sure patient is stable.Step I : Emergent management: Not needed.Step II : Physical Examination General Appearance, skin, lymph nodes, HEENT/Neck, Chest/Lungs, Heart/Cardiovascular, Abdomen, extremities, Neuro.Step III : Diagnostic Investigations: HPI describe a patient with splenomegaly, anemia, and jaundice. Patient was treated with bactrim few days prior to presentation which makes you think of G6PD. Patient should be workup for anemia especially G6PD.1. CBC/D- will show Normochromic Normocytic Anemia2. Peripheral Smear- Heinz bodies (bite cells) only seen on crystal violet staining of peripheral Smear. Will not be seen on wright-stained blood smear.3. reiculocyte index >3% (reticulocytosis)4. LFT- Serum bilirubin elevated5. Urinalysis- Hemoglobinuria6. Erythrocyte G6PD Assay- Low enzyme level.7. Type and cross- If hemoglobin is low-severe cases may need transfusionTreatment: Stop BactrimIv Access and IV fluid-NSSStep IV: Decision about changing patients location Admit to wardContinue IV fluid until diagnosis is established and patient has improved.If evidence of infection – Treat with non- sulfa drugsWhen patient is stabilized Cancel IV and Move patient home.Step V: Educate patient and family:Console patient on food and medications that can cause problem1. seek medical attention for any infection2. avoid food containing fava beans3. Medications including: acetanilid, dapsone, Bactrim, nitrofurantoin, sulfacetamide, sulfamethoxazole, sulfonamide, sulfapyridine doxorubicin, methylene blue, nalidixic acid, naphthalene, phenazopyridine, phenylhydrazine, primaquine, quinidine, quinine,on ccs you may not have option to console patient for specific food or drug use, just select console patient!STEP VI: Final DiagnosisG6PD

CCS- Panic AttackDecember 23 2002 at 7:28 PM vetan vetan (no login)from IP address 66.141.67.118

History of present illness:A young man with Palpitation, pounding heart, anxiety come to ER for evaluation. Whenever a patient, regardless of age or risk factors, reports to an emergency room with symptoms of a potentially fatal condition i.e MI, a complete medical history must be obtained and a physical examination performed. DDX is numerous including: cardiovascular d/o, Pulmonary diseases such as asthma, Neurological diseases, endocrine disorders, Drug intoxication, Drug withdrawal such alcohol, and Anaphylaxis.VITAL SIGNS- make sure patient is stable- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)Allergy: NKASStep I : Emergent management: Not needed. Unless respiratory distress is present.Step II : Physical Examination General Appearance, skin, HEENT/Neck, Chest/Lungs, Heart/Cardiovascular, Abdomen, Neuro.Step III :

Diagnostic Investigations: Following labs will eliminate any possible cause. With normal tests, panic attack is diagnosed. Presence of atypical symptoms such as vertigo, loss of bladder control and unconsciousness or the late onset of the first panic attack >45 years old require further evaluation.

1. O2 SAT. Asthma, COPD.
2. CBC- rule out anemia, Infection
3. Chem 12- electrolyte abnormalities(glucose, Ca, BUN, Cr).
4. TSH- Hyperthyroidism
5. LFTs
6. UA
7. Urine Drug screening
8. EKG

Treatment: Usually not needed but can use Xanax 0.5mg once. Step IV: Decision about changing patients location

1. If All test results are Negative and patient is stable, Move patient home. Schedule office appointment
2. If patient continues to have panic attacks at a later time/date, consider drug treatment with Benzodiazepines, SSRI, TCA, MOAIs, Treat for 8-12 months. Consider adding cognitive and behavior therapies as combination is superior than either one alone. SSRI are considered the initial drug of choice i.e sertraline.

Step V: Educate patient and family: Avoid caffeine and medications that can cause panic attack including: yohimbine, pseudoephedrine, flumazenil, cholecystokinin, and isoprenaline.

STEP VI: Final Diagnosis Panic Attack

CCS- Tension pneumothorax
December 23 2002 at 7:26 PM vetan vetan (no login) from IP address 66.141.67.118

This case is from a CD that is being sold at <http://www.passfirst.com> the CD claim to have all 5 cases of usmle sample solved like this one and multiple questions. I don't know how good this CD is. If anyone has used it please let us know if it is worth the price.

NOTE: FOR COPYRIGHT REASONS, WE ARE NOT ALLOWED TO REPRODUCE THE QUESTIONS. YOU MAY HAVE TO DOWNLOAD THE TEST FROM THE USMLE'S WEBSITE, AND INSTALL THEM ON YOUR PC BEFORE YOU REVIEW THIS SOLUTION

CASE #1: 65-year-old white man with chest pain

Case Introduction: Essential Facts

- Patient is white, in mid-sixties
- Has sharp, right-sided chest pain, accompanied by respiratory distress
- He was brought to the emergency department

Comments: There is nothing that connects being white with having chest pain. This patient could have been of any racial origin and still present with these clinical features. However, the patient's age will affect our choice of differential diagnoses. Chest pain in an older man is more likely to be of cardiac origin than the same pain in young patients.

Possible differential diagnoses at this stage include

- Pulmonary embolism (PE) because of chest pain, respiratory distress
- Lobar pneumonia (chest pain, respiratory distress)
- Tension pneumothorax (chest pain, respiratory distress)
- Musculoskeletal chest pain (pain in a specific location)
- Pleuritic chest pain
- Cardiac pain (this is less likely, though possible. A patient with dextrocardia who develops myocardial infarction may have right-sided chest pain. However, since this test is based on clinical conditions commonly seen in practice, we are not going to be too concerned with this differential)

Initial Vital Signs: Essential Facts

- There is tachypnoea and tachycardia
- Blood pressure is low
- Temperature is normal
- The patient is obese (BMI of 29)

Comments: Pneumonia as a cause of this patient's chest pain is effectively ruled out because of the normal temperature. Still high on our list are PE, pneumothorax, and the other differentials listed above. Patient's obesity will be addressed at a later time

Initial History: Essential Facts

- Chest pain began 10 minutes before arrival at the ER
- This is the first episode of chest pain
- Patient has had

chronic lung diseases that may predispose to pneumothorax• Chest pain increases with respiration• He was not involved in strenuous activities immediately before the onset of chest pain

CommentsAlthough, this pain increases with respiration, a musculoskeletal cause is unlikely, going by the patient's recent history. He is an accountant who suddenly developed an excruciating chest pain while at work. There is no recent history of chest trauma. Because of his long-standing history of asthma and emphysema, we will add emphysema to his differentials, since the latter can cause a measure of chest discomfort, especially if there is associated chronic obstructive pulmonary disease (COPD). However, uncomplicated emphysema does not cause sudden sharp chest pain. It is time to perform the physical examination. Click the button labeled Interval History or PE and select • General Appearance• Chest/Lungs and • Heart/CardiovascularWe are interested in the general appearance (this is standard when interacting with most patients. You should always examine the patient's general appearance). Moreover, because the primary complaint is in the chest region, we would naturally want to examine that area. Also, considering the patient's age and the possibility that his heart might be the cause of his problems, we want to examine the heart as well. We cannot do more detailed examination of other systems because this is an emergency. Press OK to confirm your choice.

History and Physical: Essential Facts• Patient is cyanotic and in marked respiratory distress• There is chest asymmetry, with hyper-resonance on right side. Breath sounds are also absent on that side• Cardiac examination essentially normal• Peripheral pulses present but weak• No pulsus paradoxus (a fall in pulse amplitude with quiet inspiration)

CommentsNotice the results of physical examination. We seem to have enough reason here to believe that this patient has tension pneumothorax. However, we would still like to confirm this with further tests.

FAQ: Since this patient is in severe pain, and his vital signs are abnormal, why can't we just go ahead and treat?**Answer:** Although this is a relative emergency, it is clear that we have enough reason to investigate the cause of the patient's problems further before we initiate treatment. First, we can still measure his blood pressure (although this is low). There is no pulsus paradoxus. We are not going to waste time on nonessential investigations however. It is important to try and establish the cause of patient's problems, if possible, before we initiate treatments. Now, let us write orders. If the result of the History and Physical is still visible, click OK to close it. Next, click the button labeled Write Orders or Review Chart. Next, click Order button at the bottom of the screen, and enter the following orders (one on each line):• Chest x-ray• Oxygen• Morphine• ECG

Confirm the orders by clicking the Confirm Order button. For chest x-ray order verification, choose Chest x-ray, portable. Click OK. Urgency: stat.

Note: Although, Chest X-ray PA/lateral may give you more detailed information, it takes more time. Moreover, the patient has to be wheeled to the X-ray department before the films can be taken. Portable chest x-ray can be done right there at the ER, and it takes very little time.

For oxygen, choose Inhalation for route and Continuous for frequency. For morphine, choose Intravenous for route and Continuous for frequency. **Note:** morphine is almost always given through the intravenous route for most conditions. In any situation where you have need to use morphine, consider this fact. Don't let the frequency that we chose mislead you. Continuous administration here means that it is given at fixed times (e.g. 6 hourly, 8-hourly, etc).

For ECG order verification, choose ECG 12-lead; Urgency: stat. Now that we have initiated treatment, it is time to review that patient with the next available result. From our Order Sheet, we can determine that the

result of the portable chest x-ray will be ready within 10 minutes. So let us advance the clock to that time. Click the button Obtain Results or See Patient Later at the top of the screen, and choose Review Patient with Next Available Result. The test result is displayed. Chest X-ray findings: Right tension pneumothorax. Next, we are going to write more orders for this patient. Click the Order button at the bottom of your screen and type thoracentesis. Scroll to the bottom of the form and choose Thoracostomy tube. Confirm your choice. The result of this procedure is immediately displayed. When you click OK, the result of the 12-lead ECG will be displayed, showing essentially normal findings. It is now time to advance the clock, so we can re-evaluate our patient in 15 minutes. Click on the clock at the top of the screen and choose • Re-evaluate case In, then • type 15 in the Minutes box (you may also use the upward pointing arrow to do this). Click OK. Now that our patient has been stabilized, we would like to perform an interval follow up before we admit him for further management. Towards the left side of the screen, click Interval History button, and choose • Interval Follow Up, • Chest/Lungs under the Physical Examination section. The important findings this time are: • Patient is a smoker (for 45 years) • He has a positive family history of cardiac disease, hypertension, obesity, and stroke. • As noted earlier, the patient is obese (he has a body mass index of 29) • Patient does not engage in regular exercise (dyspneic after 1 minute of brisk walk) • The chest is now symmetrical. Some of this information will come in handy when it is time to address the patient's health maintenance issues. For now, we would like to send him to the intensive care unit. FAQ: Since the patient has been stabilized, why can't we just admit him to the ward instead of the ICU? Answer: Under the British medical care system (and, incidentally, this is also true of many third world countries), we would have sent the patient to the ward. However, in the United States, patients like these are sent to the Intensive Care Unit. FAQ: Why can't this patient be discharged home right away, since he has been relieved of his problems? Answer: he has a chest tube in place. The general consensus is that the chest tube should remain in place until we are sure it is no longer needed (i.e it does not show any bubbles in the water seal.) Even then, some hospitals prefer to clamp the tube and observe for some more time, before they remove the tube entirely. Click the Change Location button, and select Intensive Care Unit (ICU). Confirm move. Recorded vital signs are displayed (much better this time around). Click OK. We must now add more treatment for the patient. Click Order Sheet on the left side of the screen, and Order button at the bottom. Enter the following orders (one per line): • Albuterol (inhalation, continuous) • Atrovent (inhalation, continuous) • Advise patient, smoking cessation (routine, start now) • Advise patient exercise program (routine, start later) • Advise patient, weight reduction (routine, start later). Next, we are going to re-evaluate the patient in 1 day. Click the clock, and advance the next evaluation to 1 day. The dialog appears telling you you have five minutes more, and asking for the final diagnosis. Final diagnosis: Tension pneumothorax. End of case.

CCS- Cardiac Tamponade December 23 2002 at 7:24 PM vetan vetan (no login) from IP address 66.141.67.118

History of present illness: A 59 year old man involved in MVA, chest impacts the steering wheel, comes in with distant heart sounds, dyspnea, obtundation. Vital signs- BP. Pulse,

RR, Temp. This patient requires Step I with ABCD. With Steering wheel injuries one should be concerned about fracture of sternum, ribs, trauma to lungs, spleen, Liver, and myocardial contusion. This patient with distant heart sound gives you the clue to possible pericardial effusion. Signs of cardiac tamponade include, the following: distended neck veins, decreasing blood pressure, narrowing pulse pressure, muffled heart sounds, pulsus paradoxus, and equalization of hemodynamic pressures (CVP). Step I : Emergent management: A, B, C, D- Supplemental oxygen, Cardiac monitoring, Intravenous access Step II : Physical Examination General appearance HEENT/Neck- check for distended neck JVD Heart/CV- Distant heart sound Chest/Lung, Abdomen, Extremities, Neuro. Step III : Diagnostic Investigations: 1. EKG- electrical alternans 2. CXR 3. Echocardiography- the most sensitive and specific noninvasive test for the presence of fluid in the pericardium. Treatment: 1. IV Fluid 2. Pericardiocentesis 3. If vital signs are lost in ER, an immediate thoracotomy is indicated. 4. Consult for thoracotomy 5. Presurgical workup- CBC, BMP, CXR, PT, PTT, EKG, Type and cross match, IV antibiotic. 6. Urine drug screening 7. BAL Step IV: Decision about changing patient's location After surgery transfer patient to ICU and monitor EKG, repeat CXR and complete physical exam. When patient is stable move to ward, then move home. Step V: Final Diagnosis: Cardiac Tamponade

CCS- HEAD INJURY December 23 2002 at 7:23 PM vetan vetan (no login) from IP address 66.141.67.118

HEAD INJURY History of present illness: An 18 year old white male fell to the ground while playing soccer and was unconscious for 2 mins. He is complaining of headache but he cannot recall the incident. His friends state that after the time of injury, he has difficulty walking. VITAL SIGNS- Check vitals to make sure pt is hemodynamically stable. BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F) Allergy: NKA DDX: 1) Concussion 2) Contusion 3) Epidural/Subdural Hematoma. Step I : Emergent management: ABCD- if patient unstable O2, IV access Step II : Physical Examination Focus: HEENT/Neck, chest/lungs Heart/CV, abdomen, Extremities, Neuro/Psych. Step III : Diagnostic Investigations: 1. CBC 2. Chem-73. Type and cross match 4. Continuous monitoring of vital signs, oximetry, EKG 2. Order CT SCAN of head without contrast. 3. Move the clock and get results. 4. If CT Scan shows epidural or subdural hematoma and patient is stable get Neurosurgical consult for Emergent Evacuation of the Hematoma. 5. If patient is unstable due to increased intracranial pressure do #4 and start IV mannitol. If not effective then #66. Intubate the pt. and hyperventilate to pCO2 of 35mm Hg Step IV: Decision about changing patient's location 1. Patient with Neurologic signs should have emergent surgery. 2. Neurological check up every 1 hrs. 3. Repeat CT after 24 hrs. If CT is Normal and patient is stable move home with office follow up in 5-7 days. STEP V: Educate patient and family: Patient with head trauma and initial normal CT should be informed to return to hospital immediately if he develops Neurologic signs which requires Emergent CT. STEP VI: Final Diagnosis. Epidural Hematoma

CCS- Pneumocystis Carinii Pneumonia with Candida Vaginitis. December 23 2002 at 7:22 PM vetan vetan (no login) from IP address 66.141.67.118

History of present illness: 40 year old homosexual female, cough and fever, vaginal itching. Note where the patient is on presentation, if she is in your office after initial work up, patient should be transferred to Ward or ICU (depending on presentation but most likely to ward). Unless the symptoms are mild in that case treat patient in the office.

VITAL SIGNS- will help you to determine if patient is stable or unstable. BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp. (N= 37C, 98.6F) Allergy: NKADDX- Pneumocystis pneumonia- Top of your list because of risk factor and OI at presentation. Cytomegalovirus Kaposi Sarcoma Legionellosis Lymphocytic Interstitial Pneumonia Mycoplasma Infections Nocardiosis Bacterial Pneumonia Fungal Pneumonia Viral Pneumonia Pulmonary Embolism Tuberculosis

Step I : Emergent management: A, B, C, D- depending on presentation and assessment of O2 sat. if O2 sat is low. Start with one liter O2 and get IV access.

Step II : Physical Examination Any suspect HIV/AIDS patient should have a complete physical exam. General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Genitalia, Extremities, Neuro.

Step III : Diagnostic Investigations: 1. O2 sat.- Pulse oximetry is obtained as part of the initial workup 2. ABG- with signs of respiratory distress. (hypoxemia) 3. LDH- Levels are noted to reflect disease progression. High levels during treatment indicate therapy failure and worse prognosis. 4. CBC/D- 5. Chem-126. CXR- The classic finding is diffuse central (perihilar) alveolar or interstitial infiltrates. Normal CXR is found in 5-10% of cases. 7. Sputum- by-sputum induction for Wright-Giemsa stain or direct fluorescent antibody (DFA) for Pneumocystis if PCP is strongly suspected. If negative and PCP suspicion is high next step is bronchoalveolar lavage. 8. HIV test- when you order a test like HIV that requires patient consent, it will tell you that patient consented to the test and result will be available in 7 days. 9. CD4 count 10. PCR assay 11. Saline or KOH Vaginal secretion (wet mount). 12. LFTs 13. VDRL, Toxoplasma IGG, and hepatitis B and C serologies. 14. Cervical papanicolaou Smear 15. TB skin test.

Treatment: 1. IV fluid –NS (In moderate- severe cases). 2. If suspicion is high for PCP start treatment with Bactrim-DS po bid for 14-21 days. If patient is hypoxic, start with Bactrim IV. 3. Report positive result to Department of Health and Human services.

Step IV: Decision about changing patient's location 1. Mild-to-moderate disease refers to patients with milder symptoms and a nontoxic clinical appearance. They generally are not hypoxic and may even have a normal CXR. Outpatient oral therapy can be considered for these patients. 2. Moderate-to-severe disease describes patients with severe respiratory distress, hypoxemia, and, often, a markedly abnormal CXR. Inpatient management with rapid diagnosis and treatment is essential. 3. Admit patient to ward for moderate to severe disease. (ICU if patient unstable). Mild cases should be managed outpatient. 4. Discontinue IV fluid if patient is taking po and is not dehydrated. 5. Continue Bactrim - 6. Treat Vaginal candidiasis with antifungal such as nystatin, clotrimazole, miconazole vaginally. 7. When diagnosis of AIDS is established start Antiviral therapy with: A. 2 NRTIs + 1 or 2 PIs. B. 2 NRTIs + an NNRTI 8. Vaccines: Influenza, Hepatitis A and B, Pneumococcal vaccine. 9. when patient is stabilized cancel IV fluid, move patient to home with follow-up in your office in 5-7 days. 10. Continue Bactrim and antifungal- discontinue antifungal when patient returns for follow-up unless symptoms still persist in that case consider changing antifungal.

Step V: Educate patient

and family:1. Educate patient on safe sex. 2. Educate patient on Medication compliance.3. Console patient on HIV support group. When you request this option it tells you arrangements for follow-up has been made.Step VI: Final Diagnosis:Pneumocystis Carinii Pneumonia (PCP) with Candida Vaginitis

CCS- Sigmoid VolvulusDecember 23 2002 at 7:21 PM vetan vetan (no login)from IP address 66.141.67.118

History of present illness:63 years old man brought to Emergency Room complaining of colicky abdominal pain.When reading HPI note following:VITAL SIGNS- make sure patient is stable- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F)Allergy: NKADDX- Bowel obstruction, -carcinoma Pseudo-obstruction (ileus)Giant sigmoid diverticulumConstipationStep I : Emergent management: ABCD- Not neededStep II : Physical Examination General appearance Abdomen- Examination reveals a tympanitic/distended abdomen, and a palpable mass may be present. Severe pain and tenderness suggests ischemia/perforation. Bowel sounds are usually absent.Rectal exam- Rectal examination shows only an empty rectal ampulla. Skin, Chest/Lung, Heart/CV, Extremities, Neuro.Step III : Diagnostic Investigations: 1. CBC- Leukocytosis (in some cases Leukocytosis may be absent)2. Chem 7- to evaluate any electrolyte abnormality3. X-ray of Abdomen- Diagnosis of sigmoid volvulus can be made by using plain abdominal radiographic findings Plain radiographs show a markedly distended sigmoid loop, which assumes a bent inner tube or inverted U-shaped appearance, with the limbs of the sigmoid loop directed towards the pelvis. Also dilated gas-filled lumen, can result in a coffee bean-shaped structure; this is the coffee bean sign. 4. If diagnosis is questionable Barium Enema will confirm diagnosis but is contraindicated in suspected perforation.Treatment: 1. IV access- IV Fluid with LR2. GI consult- reason for consult, evaluation and decompression of possible sigmoid Volvulus.3. Sigmoidoscopy- decompression and untwisting of the sigmoid loop with placement of long soft tubeStep IV: Decision about changing patients location 1. Admit to ward2. Continue IV fluid3. Monitor patient for 2-3 days after decompression for persistent abdominal pain and bloodstained stools, signs that may herald ischemia and indicate the need for surgical intervention.4. Consult General surgery- Surgery is reserved for patients in whom tube decompression fails or for those in whom signs of ischemia are suggested. Surgery also has a role in an elective situation when the volvulus repeatedly recurs.5. After patient is stabilized, move patient home with office follow-up in 5-7 days. Step V: Educate patient and family:Console patient to seek medical care if Nausea, Vomiting , Rectal bleeding or abdominal pain reoccur.Console on low fat, high fiber diet.STEP VI: Final DiagnosisSigmoid Volvulus

CCS- DKA vs Hyerosmolar stateDecember 23 2002 at 7:19 PM vetan vetan (no login)from IP address 66.141.67.118

History of present illness:25 yo woman, with abdominal discomfort and confusion (blood sugar over 600 mg/dL).Note vital signs: BP, Pulse, Resp. Rate, Temp. Check vitals to

make sure pt is hemodynamically stable. Is there History of diabetes? (new onset ?) DDX: KDA vs hyperosmolar state
 Step I : Emergent management: A, B, C, D- IV access followed by 0.9 NS (pt. with hyperosmolar and hypotension from hypovolemia use NS otherwise ½ NS is preferred because of marked hyperosmolar state) , IV insulin
 Step II : Physical Examination General appearance, skin, HEENT/ Neck, Chest/Lung, Heart/ CV Abdomen, Neuro/Psych
 Step III : Diagnostic Investigations: 1. CBC 2. Chem 123. FSBS 4. ABG 5. UA 6. ABG 7. serum ketone 8. Amylase and Lipase (usually positive in abd. Cause) 9. serum osmolality 10. EKG 11. Hgb A1c
 Treatment: 1. Continue IV hydration with NS until blood sugar is around 250 mg% then consider D5 ½ NS. Change insulin to subq instead of IV 2. Monitor potassium , phosphate and Mag. And replace.
 Step IV: Decision about changing patients location 1. Patient need to admitted to ICU initially then to ward when stable 2. After patient is stabilized investigate the cause if is still unclear. 3. Discharge home with follow up visit
 Step V: Educate patient and family: Educate patient on diabetic diet, exercise , signs of hypoglycemia
 Final Diagnosis: Key points in differentiation between DKA and Hyperosmolar is as follow
 DKA: 1. hyperglycemia >250 Mg/dl 2. Acidosis with blood PH < 7.33. Serum bicarbonate < 15 meq/dl 4. serum positive for ketones
 Hyperglycemic hyperosmolar state: 1. Hyperglycemia >600 Mg/dl 2. Serum osmolality >310 mosm/kg 3. No acidosis; blood PH above 7.34. Serum bicarbonate >15 meq/L 5. Normal anion gap (< 14 meq/L).

CCS- Acute cholecystitis December 23 2002 at 7:18 PM vetan vetan (no login) from IP address 66.141.67.118

History of present illness: Most likely a 42 year old female was having lunch developed abd pain with nausea and vomiting. Note: BP, P, RR, HR, quality of pain, duration of pain.
 DDX- 1. Acute pancreatitis 2. Ulcer 3. Diverticulitis 4. Pneumonia 5. hepatic abscess 6. hepatic tumors 7. irritable bowel disease 8. Non-ulcer dyspepsia 9. Pancreatitis
 Step I : Emergent management: Most likely not needed.
 Step II : Physical Examination General appearance, Heent/Neck, skin, chest/lung, heart/CV , Abdomen
 Step III : Diagnostic Investigations: 1. CBC w/diff. – (leukocytosis 12000- 15000) , Chem 12, amylase, lipase, LFT (Ast, Alt, and GGt will be slightly elevated), fasting Lipid profile. 2. Upright abdominal X-Ray (15% calcium stones) 3. USG if questionable do Tc-99m-IDA (HIDA)- if USG shows no stone and HIDA is positive consider Acalculous cholecystitis. 4. pregnancy test especially if result not clear or medication is to be given
 Treatment: For patient who are sick enough to be admitted. 1. NPO 2. IV Fluid 3. demerol for pain 4. Nasogastric suction
 Step IV: Decision about changing patients location 1. If mild can be treated outpatient with low fat diet and actigal 2. Admit If pain is >6 hour and showing toxicity, Jaundice, rigors, or requiring narcotics for pain. 3. Admit to ward 4. surgical consult- if no perforation or CBD obstruction 5. If surgery is to be done prepare with CBC, chem 7, CXR, PT, PTT, cross and match, EKG 6. Antibiotics cefotetan, or clindomycin and gentamicin 7. when patient stabilize discharge home
 STEP V: Educate patient and family: Avoid fatty meals, stop smoking, exercise
 STEP VI: Final Diagnosis. Acute cholecystitis
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Vetan's CCS cont

CCS- DYSFUNCTIONAL UTERINE BLEEDING December 23 2002 at 7:16 PM vetan
vetan (no login) from IP address 66.141.67.118

History of present illness: A 14 yr AAF girl with profuse vaginal bleeding comes to ER. She had her menarche 3 months ago and had irregular bleeding since then. 1. Note vital signs: BP, Pulse, Resp. Rate, Temp. 2. Check vitals to make sure pt is hemodynamically stable. If patient unstable do step I. For any female with abnormal vaginal bleeding you should check: 1. age of the patient 2. Family history of bleeding disorder 3. history of irregular cycles 4. evidence of bleeding problem on physical exam i.e. petechia

Differential diagnosis of vaginal bleeding 1. dysfunctional uterine bleeding secondary to anovulation 2. endometrial neoplasia 3. endogenous source of estrogen i.e. granulosa cell tumor 4. uterine myomas with submucous myomas 5. hematologic disorders such as leukemia and idiopathic thrombocytopenia 6. endometritis and endometrial polyps

In this 14 year old female with h/o irregular cycles and no other signs on physical exam you should think of DUB secondary to anovulation which usually occurs in extremes of reproductive age, menarch and perimenopausal women.

Step I : Emergent management: A, B, C, D- if patient stable move to step II

Step II : Physical Examination

Do a focus PE: general, skin, chest/lung, heart, abd, genitalia, extremities

Step III : Diagnostic Investigations: 1. Pregnancy test 2. CBC- will show Hgb 7.0 – do cross and match if patient is hypotensive or symptomatic start IV access and consider NS 3. Chem 12 (glucose included), coagulation profile, TSH, ESR

Most likely in this case all test will be neg. except abnormal CBC.

Treatment: This patient is bleeding profusely and her Hgb is 7.0 so start estrogen IV 25mg q4h x3. And Ferrous sulfate 325 mg. Po tid

Bleeding should stop. Recheck CBC.

Step IV: Decision about changing patients location 1. Move patient to ward because her Hgb is low. 2. Repeat CBC following day and start OCP 3. MVI one daily 4. Continue ferrous sulfate 325 po tid

If patients Hgb is stable discharge patient home with office follow up in one week

Consult on safe sex. In office repeat CBC if has improved follow up in 3 weeks at that time you may D/C OCP and iron pills if you want to. (3 weeks of treatment is recommended with OCP). If patient desires you can continue OCP.

Final diagnosis: DYSFUNCTIONAL UTERINE BLEEDING

CCS- Alzheimer Dementia December 23 2002 at 7:15 PM vetan vetan (no login) from IP address 66.141.67.118

History of present illness: A 79 year old female comes to your office complaining of forgetfulness. The first and most important initial evaluation of patient with dementia is History and Physical examination. Important clues such as onset, duration, etc.. will narrow your diagnosis and required investigating labs. Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F) Allergy: NK ADDX: Alzheimer's dementia- Most common. Vascular dementia- 2nd Most common. Pick's disease –3rd most common. Lewy body disease Huntington's disease Parkinson's disease HIV- Related dementia Head trauma related dementia Step I : Emergent management: A, B, C, D- Not needed. Step II : Physical Examination General appearance, Skin, Lymph Nodes, HEET/Neck, Chest/Lung, Heart/CV, Abdomen, Extremities, Neuro/Psych. Step III : Diagnostic Investigations: There are several diagnostic investigations for workup of dementia but H&P exam will narrow the list. 1. MMSE 2. CXR 3. EKG 4. CBC/D- To check for anemia. 5. UA 6. SMA-12- check for electrolyte abnormality 7. TSH- to rule out thyroid problem. 8. VDRL- To rule out syphilis 9. B12 level 10. BAL- guided by H&P 11. Urine Drug screening and heavy metals- guided by H&P 12. HIV test – guided by H&P 13. CT – guided by H&P 14. LP- guided by H&P Initial Treatment: Not needed. Step IV: Decision about changing patients location 1. Some of the test you order may not be available right away, move patient home and schedule office appointment when all results are available. 2. Need to see patient initially weekly then monthly. Treatment: 1. When diagnosis of Alzheimer is made by H&P and exclusion of other possible causes of dementia, start either Tacrine or aricept .2. Add Vitamin E – it has shown that may slow progression of Alzheimer 3. Treat other complains that patient may have such as insomnia etc. Step V: Educate patient and family: 1. Educate patient and family about the disease 2. Console patient on driving restriction 3. Educate patient on Living will. 4. educate patient on exercise and Alzheimer support group. Step VI: Final Diagnosis: Alzheimer Dementia

Chemotherapy Induced Neutropenia December 23 2002 at 7:13 PM vetan (no login) from IP address 66.141.67.118

History of present illness: A 50 year old lady with a history of chemotherapy post a successful breast surgery who came to the office with a low grade fever. Patient with history of chemotherapy and fever should make you think about possible infection secondary to immunocompromised status. First step is to get a good history and Physical exam. PE will help you eliminate any opportunistic infection. Note vital signs- BP (N= 90-140/60-90), Pulse (N= 60-90, Mean- 72), RR (N= 12-20, Mean- 16), Temp.(N= 37C, 98.6F) Allergy: NK A Step I : Emergent management: A, B, C, D- Not needed. Step II : Physical Examination Complete physical exam: General appearance Skin- check for skin lesions Breasts, Lymph Nodes, HEET/Neck- evidence of fungal infection. Chest/Lung- evidence of respiratory infection i.e. decreased Breath sound, rales, rhonchi. Lungs are the most frequent site of infection in Immunocompromised patients. Heart/CV, Abdomen Genitalia Rectal - look for evidence of fungal infection Extremities, Neuro/Psych.- mental status evaluation looking for meningism or focal deficits Step III : Diagnostic

Investigations: 1. CBC/D2. Peripheral blood smear3. Urinalysis, urine culture, sensitivity and Gram stain.4. Blood cultures5. stool culture6. Sputum Gram stain, AFB stain and cultures.7. If skin lesion present culture it8. LP- guided by H&P9. CXR –check for infiltrates, lobar consolidation, cavitary lesionsStep IV: Decision about changing patients location 1. If any of the diagnostic test result is positive or patients' Temp. >38.5 C with Neutrophil count of less than 500 or three elevated Temp. >38 C in 24 hours , patient should be moved to ward and board- spectrum antibiotics should be started.2. Neutropenic patient without fever can be monitored outpatient.Treatment: 1. IV access 2. Antibiotics- A. ceftazidime, carbapenemsB. Mezlocillin, piperacillin or azlocillin plus an aminoglycoside or third generation cephalosporin. Treat for 10-14 days or until Neutrophil count is >500.3. Consider use of Neupogen (G-CSF) Step V: Educate patient and family:Console patient to avoid people with cold/flu Console patient to seek medical help if a fever developsStep VI: Final Diagnosis:Chemotherapy Induced Neutropenia

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ccs cases from last 3 months

sep10. Most of the CCS from you r website

- 1) 16 yr old for RHM had elevated BP also..... So with weight loss it came down
- 2) 18 yr old came with dysuria..... Preg test positive therefore did all the prenatal workup and had a uti so treated with amox
- 3) Patient 74 yr old admitted on the floor with pneu developed SOB turned out to be PE
- 4) 15 month old infant brought for lethargy and tiredness was Iron def anemia
- 5) 30 yr old with menorrhagia and bruisingplatelets low, other labs normal.... was ITP
- 6)60 yr brought for suicide attempt, took unknown tablets.....pupil 4,messed up on this because was not able to find what she had taken
- 7) 54 yr old came to office with CAP

8) 50 year old man with H/O asthma and came with weakness to office.....did cbc, sma7,Went round and round started inhaled steroids but no improvementthen hb came low did fobt which was positive so did colonoscopy which was negative.....did EGD which showed duodenal ulcer with hpylori positive treated for hypylori patient felt better

9) 35 year lady with history of sickle cell came with abdominal pain RUQ.....did US showed cholelithiasis.....surgery consult and then went for surgery

Aug 1st ccs))Office-Heart failure, because of CAD, on ACE inhibitor, needed diuretic and digitalis but!!!! because of initial renal failure and hyperkalemia, already Ibuprofen because of osteoarthritis you have to cancel it-IBU, immediately and give him acetaminofen, not admission, home with follow up.

2.)))ER, Heroin addict, high fever, abscess on the arm=infective endocarditis, put him on meticillin, you will get blood culture resistance than, than !!cancel meticillin and put him on vancomycin. BUT he has articular pain and agitated because of abstinence, put him on methadon, iv, of course.

From this two cases you can see, not just to manage, you have second problem too, that is why are the people surprised that they didn't do well, they expected.

3.)))13 young girl, massive menstrual bleeding, give her conjugated estrogen, AND, AND, many has a question!!! What is the cause, take coagulation battery, you will see-von Willebrand!! if you read history dad had some coagulation problems (-dominant-vW, cannot be hemophilia and factor VIII, you will lose the case)

4.))Sickle cell, give him O2, hydration, Morphine, don't give him transfusion, you will get the answer "parents doesn't want to give consent"

5. Chron's-order colonoscopy, she was young, not sigmoidoscopy, hasn't cancer, you will get minus points. give her steroids.

6.))Crash-sy, hyperkalemia 1. calcium iv 2. bicarbonate, hydration, measure urine output, put him on dialysis if needed

7.))cardiac tamponade, young lady, car acc.-JUST physical, a)general app, b)heart, c)lung, they will tell you pulsus paradoxus, AND!!!!!!!!!!pericardiocentesis on the spot otherwise you will lose. After!!!EKG, ENZYMES, X-Ray because she had fracture of the sternum, give her something strong for her pain iv, don't forget PAIN, send her in intensive c.

July 30 th at 1.30r found to have 1 cm lump in breast. has already seen gen surg and is scheduled to have it removed. Now needs pre-operative clearance. On exam she has bruises on her legs and petechiae. CBC is normal except for 10,000 platelets. She has ITP.

2. 18 yo girl comes in for pre-college physical. no complaints but she has a bp of about 180/95. She is a little overweight (145 lbs at 64 in), smokes and is sexually active. She needs a pap/pelvic exam. With diet modifications, smoking cessation and losing weight, her bp is normal at the follow up in a month.

3. 60ish lady in the hospital for strep pneumonia getting better on abx but suddenly has shortness of breath. Nothing else on exam (no leg pain even). She ends up having a PE. This case annoyed me because even after I anticoagulated her and gave her pain meds she wasn't getting any better, She ended up needing to go to the OR for a thrombus-ectomy and then the case said that she was recuperating well.

4. 19ish month old male who is a fussy eater and only drinks a ton of milk and a pint of juice a day. refuses all meats and veggies. He is pale and fatigued, he has iron deficiency

anemia. (lead level is okay) Mom needs to be counseled on less cow milk. He sees nutrition and takes FeSO₄ and he's better in a month.

5. lady in her 60s found by boyfriend with half a bottle of alcohol and lots of empty prescription bottles next to her. no one knows which meds. Sh comes to you comatose. - has a little benzos, a little TCAs, a little etoh.

6 Guy in his 60s c/o feeling tired all the time and occasional heartburn type chest pain. On exam he is really pale. no stool in his rectal vault to guaiac so you have to type "hemoccult stool" as an order. it comes back positive and his CBC has a low Hb (like 8ish). I thought I have to find out if he's got an active bleed so i sent him to the er and had him NG lavaged (clear) and then scoped from up and down. he had a duodenal ulcer and a positive H Pylori. Gave him meds and he felt better a month later at follow up.

7 26 yr old came to office for dysuria. hx says married and "occasionally" uses condoms for protection with husband. Urine HcG positive and UA has like 3 wbc's and + leuk esterase. you tx everything in pregnant ladies so i gave her some amox. cx came back with >100000 cfu ecoli sens to amox. she felt better and she and her husband were excited about the baby. I also gave her prenatal vitamins and did a pap/pelvic and some titers (rubella, VDRL/HIV screen)

aug 1st ccs

1. 5 yrs old blk kid brought by mother for yellow eyes .had otitis media and was given bactrim for treatment.otherwise ok .vaccines up to date expet varicella.

wu cbc,ua,haptaglobin,ldh,bili d&t,coombs

rest at home. dc bactrim,mother was concerned about yellow color, reassured mother.

fu in a wk .case finish .

i gave varicella vacn and g6pg after 2 months

2. 22m old kid brought by mother for regular check up .

drinks a lot of milk. teenage mother works and grandmother babysits .baby is pale.stool guaiac +

wu cbc,ua lead level

microcytic hypochromic anemia

so ferritin ,iron and tbc level

iron & ferritin were low but tbc was in high normal range

put him on ferrous sulfate

could not tell mother to reduce milk so i just put him on diet high in iron

forgot to give him varicella shot .called him in 10 days to do a retic

3. 27 yrs old girl goes to college .multiple sexual partners.comes for physical

wu cbc,ua,pap smear + CIN3 colposcopy, cin3+ so did cervical cryo ablation,age appropriate counselling

4. 18 yrs old ss disease feels pain in epigastrium 4 mths some time wake up at night,

wu cbc, retic, cxr, us abd

ther were gallstone in the bladder so i asked for surgery, they said it willbe done so i prepared for sugery exept i for got to admit her. after 5 min come you caanot change the location.

5. 22 yrs old woman comes with urn frequcyn and irritation. divorced lives with boyfriend last prd were little
wu ua, bhcg,cbc, she is pragnent, leukocit estrase + nitrite + bactria in urine gave her ampicilline
did rubella screen, vdrl, forgot hb sreen, but asked for pap smear

6. 70 yrs old fe came in er with dificulty breathing otherwise very healthy bad teeth
wu cxr cbc esr she had pneumonia admitted her put her on cefuroxim, she felt better the next day so i changed her to po ceclor.case finished

7. 16 byrs old fat boy for sport phyl bp 145/95
wu cbc,ua,total choles, cheked bp 3 times than advised him diet exercise ,he came back in a moth with nl bp gave age appr counselling

8. 54 yrs old with pain abd llq.
wu cbc, xr abd,ct which showed diverticulitis gave him bactrim iv and ceftriaxon, felt better in 2 days
case finished

9. 58 yrs old librarian admitted for pneumonia. colon surgery 2 yrs ago on ceftriaxon and zithro, 2 days after addmission is sob
wu cxr nl , cbc, abg (forgot),vq scan +for pe
i did an echo also which was nl they said pt is having difficulty breathing i gave him frusamide as ther were some crepitus which was probably wrong

July 29 th

- . 55 year old man, smoker, COPD, SOB, Weight loss (10 lbs without diet), hurt burn. (I did not get diagnosis) (Turn out to be GI malignancy)
2. 25 year old female, left breast mass, aspirate (fluid and disappear), left breast has brown black discoloration, extremities show petecheal hemorrhage. (ITP)
3. 15 month old child, failure to growth, started at two months ago, drink milk, no vegetable (FE deficiency anemia)
4. 60 yr old female, unconscious, alcohol $\frac{3}{4}$ gone, empty multiple pill bottle (I did not get diagnosis)
5. 25 yr old female, dysuria, preg test +ve, never been pregnant (Looks like pregnancy)
6. 18 yr old female, check up for college entrance, 156/90, 175 lb. (Hypertension and over weight)
7. 19 yr old female, history of sickle cell disease, right upper quadrant pain (Cholecystitis)

8. 75 yr old female, pneumonia, 2 day of hospital admission, shortness of breath (VQ scan positive and times up)
9. I forgot.??????????????

jb ccs

August 20 2003 at 10:53 PM jb (no login)
from IP address 128.125.223.183

1. 5 yo white boy brought in by mom with past two wk of mild to moderate SOB. wheezing, symptoms are more obvious when kid plays outside. some mentioning of allergic rhinitis. Vac upto date. in office, give albuterol, symptom improve. O2 sat ok no need for oxy. mild, no prednisone given. sent home with cromyn. case of asthma. there is a asthma education found under asthma. case closed pretty soon.

2. spousal abuse. 30 yo female came in complain of some sort of chest pain (not like cardiac origen), and I sensed it is abuse from very begining. did CXR ekg and almost complete PE and found forarm bruise and left chest wall abuse mark. EKG nl and CXR 6,7ribs fracture. nothing else. Consult social and ortho for ribs. give pain meds. and message showing that the women found a shelter with her little girl. do some consel and case ends.

3. Turner. 13 yo AAF came in with mom for school related exam. girl is short and weight low but play piano, meaning ID fine. She has two other brothers are fine. There are some physical decription pointing to Turner. FSH comes back 70 and karyotype confirmed Turner. Endocrinology consult comes back saying will initiate growth and estrogen treatment, so I just prescribe them. Cardiac and GI have nothing to say. Did Echo showing bicus aortic valve etc and sent another request for cardiothoracic team to look after long term (in 5 min mark). TSH nl. I did bone age, indicating 11 year old, but no sign of constitutional delay. case closed no troble.

4. 50 somethig male comes in with fatigue and sob and PE show aortic region murmur. EKG LVH and xray indicating widening in the assending aortic/mediastinal region. Did Echo show aortic stenosis, 0.6 is the number. Sent a sonsult to cardiology and guess what saying that surgery is scheduled. I did other thing related, preop, conseling etc. and case end- aortic stenosis.

5. 60 y lady (not principle but a home worker) unconcious brought in by neibor with no clue of any etoh or drug. mentioning about the depression but no bottle found etc. RR 7, other vitals not that bad, so against my gut feeling, I ordered a HEENT and heart/lung: which only shows a 6 mm pupils. So in ABCs I did not give naloxone, becouse finger glucose is 110 so no dextrose given, i did not bother thiamine. and order the minimum, only cbc, chem 7 abg and pulse. pulse low 89 so i intubate and start mechenical. Started lavage and showing yellow fluid with fragmenets of pill etc. EKG tachy and QRS .13 so

some clue of TCA shows. Also head CT normal. Meantime, somehow urine tox back only shows positive for amitriptyline. After this, the HUSBAND showed up with a bottle (labeled with amitriptyline) found near the pillow at home with a suicide note. What a husband. Knowing the serum level is not useful, I still ordered TCA at this moment. Move pt to ICU with frequent ABG and EKG monitoring. end.

6. old lady with llq mass and pain, some time diarrhea, did xray ok, barium shows signs of diverticulitis and CT confirmed with sigmoid diverticulitis. managed with cipro/metronidazole at home and pt improved. Sigmoid diver.

7. 54 yo american indian with typical sign of DM II. Vision prob, especially at night, foot sensory etc. glucose 380. after manage with insulin lower the glucose a bit sent home metformin and all the consult. eye doc answers back with take care his retinopathy etc. educate patient and etc.

8. 50 male in Ward, post TURP has fever 39.5, chill. UA positive for nitrate and protein. I started bactrim and temp improved. I also give saline etc because his low BP. not sure if it is a septic case and blood culture never back. UTI

9. 5 month old hispanic baby with h/o OM x2 and vaccination are not clear, brought by mom. Baby is pale and listless. full w/u indicating high WBC, which I started ceftriaxone and later CSF showed gram + stain. Patient improved in ICU with message showing he can drink now so I stopped iv half saline. patient improved, and I did some education and ordered some vaccination because his unclear history on this. The computer is so slow and that it froze when I tried to type in the bacterial meni. I reported to the center. I also had some other problems with computer so the center staff aware, like that the HPI is moving around so I cannot read them easily and spent some unnecessary minutes on it. The center verify those and ask me to report.

ccs-june03

June 21 2003 at 9:52 PM BTU (no login)

-
1. tubo ovarian abscess
 2. splenic hematoma
 3. CHF+PE
 4. appendicitis
 5. DKA+UTI
 6. PID
 7. perforated sigmoid abscess
 8. lobar [pneumonia-6yold]
 9. G6PD

CCS cases

May 31 2003 at 2:39 PM bkar (no login)

- 1) pneumonia
- 2) PE
- 3) Sick Cell Crisis
- 4) Pregnancy (normal in a 23y/o on routine visit)
- 5) TTP
- 6) Fever in 8 week old baby
- 7) duodenal ulcer

ccs- August 14 2003, 2:51 PM

12 hour born baby, floppy and difficult to feed in ward. physicals show flat face and lower bridged nose.

x-ray abdomen with no air distal to duodenum.

It's a Down's syndrome with duodenal atresia. Ordered TPN and NG tube then IV fluids then ordered U/s abd and then small bowel follow through -

diagnosis came as Duodenal atresia,

then ordered chromosomal study

and then case ended ordered surgical consult and echo to look for heart but there were no signs of immediate CHF on examination

.

There is a 40 something old policeman with hx of depression on fluoxetine complain extreme fatigue. The occult blood is positive, but the colonoscopy is neg. Hx of sometimes heartburn.

I did upper scope, showed GERD. The damage is that the presentation is so vague and misleading you for colon cancer. However, it's just a simple office H2 block manage. So GERD managed

14 year old with menorrhagia,

6 month duration since the menarche.

Hg 8.2 and keeps bleeding x 10 days.

All coagulation w/u is neg. PT/PTT and Bt are all neg.

P/V vaginal clots found and gave her high dose estrogen and low progesterone and sent home. BUT at the evening the pt BP is 90/60 - (should have given IV estrogen in the office)

so called back and admitted in ward with IV RL.

pt better the next day.--- DUB

a 62 yo femal came to office complain intermittent left lower abd pain. x-ray neg, stool neg but Hg is 9. can't remember. sigmoid scope is done showed polyps. and polypectomy reported adenocarcinoma without involve the stalk. The case presentation is very vag. - adenocarcinoma of colon refered to surgery.

40 yo m with sob, vitals stable .ekg show flate votage on all leads, BMP normal. LFT normal. did start him on furosimide and then ordered echo which showed dialted cardiomyopathy. added low salt diet , upright posture and ace inhibitor case ended , added digoxin in the end,

50 year old with chest pain, sharp and related with position change. hx of one week ago with cold. ICU admitted. Ekg showed all st diffuse elevation enzymes normal gave 0 2 and asprin and prednisolone after 6 hrs patient not getting better so did an echo globular swelling showing minimal effusion with pp 10 here unnecessarily ordered pericariocentesis. got 5cc fluid and pt felt some what better.

case ended here

18 month old for regular check, picking eater, pale and thin. S.ferritin decreased. and folate and b12 are neg. CBC hypochromic and basophilic stippling Ferritin decresed lead is 48. treated with Feso4 and oralsuccsimer

21 yo f with urinary irritate. UA positive and culture sensitive foe ampic and Tmp-smz. HCG neeg. treated with tmp-smz. getting better out patient.

middle aged m, neibor find comatose. no history available. bring to er. No hx of time lag, no trace for what he is taking. RR 8/mt BP 150/100.pupils normal I gave all cokatail and ventilated did CT hemarraghe. cancelled after got CT scan result. Gave Nitroglycerin and nimodipine and pt didnot improve and case ended.

sep 28

- 1- Exacerbation of asthma
- 2-G 6 PD deficiency with sulfa allergy

- 3-UTI with pregnancy
- 4-Ovarian cancer
- 5-MI with high blood sugar
- 6-perforated peptic ulcer
- 7- DKA
- 8-Colon cancer
- 9- Normal Physical exam with HTN in young male

October 1

MVA with 3rd degree heart block
Down syndrome with duodenal atresia
ovarian torsion
cardiomyopathy
DUB
lead poisoning
SAH
colon carcinoma
oct 1st

7 yo URI take sulfa, jaundice, G6PD
62 yo pneumonia hospitalized, acute cp, PE
55yo s/p endoscope, retrosternal cp, perforation
22 yo 8w preg, grave's dz
16 yo routine physical
32 yo s/p mva, splenic rupture
18 yo uti
51 yo diverticulitis
10 yo aamb, scd, acute chest syn

thanks
hank

CF,
angina,
dermatia,
DKA,
newly Dxed DM type-II,
50yo F regular physical.
duodenal ulcer
1-Acute cholecystitis
2-ITP
3-UGI Bleeding
4-DKA
5-Bacterial Vaginosis
6-Hypothyroidism + Iron deficiency anemia

7-Alcohol Abuse

8-Pneumonia

9-foreign body aspiration(peanut)

young woman-ac asthma,gets better with Iv steroids and albuterol

2-kid with icterus,g6PD def

3-woman with no complaint except fatigue-post infectious thyroiditis(T4 high,TSH normal)propranolol took care of the symptoms

4-male middle aged-tired(like us all)we can have the luxury of saying we are depressed,he was,give SSRI

5-overweight female(lightly)...routine visit,tired pees a lot at night,only in the US they dont think its BM..give oral hypoglycemic she wont get up at night to flush

6-trip to Australia..leg swollen.I wanted a picture post card but there was this little problem of PE sent her into cyber space with elevated bleeding count..last i heard of her she was doing well.I will do well too if you pay me a trip to Australia.

warfarin etc after usual ultrasound(the damned leg is swollen) and PQ to tell higher-souls that you know it exists...CCS have nothing-well only a little- to do with what we do in real life(exam wise){p<.0005)

7-I take a break

1.5 year old African American boy present fatigue and yellow sclera after treatment with TMP-SMX. Decreased hemoglobin, increased reticulocytes, Coomb test normal, decreased G6PD. Diagnosis: G6PD deficiency.

2.28 year old African American woman present to office for post coital bleeding. Patient has many sex partners. Pap smear: CIN3. Colposcopy: White patch. Biopsy: CIN3. Do LEEP. Then biopsy: CIN3. The patient still has postcoital bleeding. Forget to do endocervical curettage.

3.14 year old obese boy blood pressure 160/95. All lab values are normal. His blood pressure improved after low fat and high fiber diet and exercise

4.56 year old came to ED for lower abdominal pain. And fever. CXR and abdominal X ray normal, abdominal CT show diverticulitis.

5.A 26 year old African American woman came to office for urine frequency and dysuria. Last menstrual period: 3 weeks ago, PE: slightly enlarged uterus. HCG: positive. UA showed leukocyte esterase. Order CBC, chem. 12, HIV, HBsAg, RPR, blood type and antibody screen, order folic acid and multivitamin containing iron. Give ampicillin, Urine culture: >100000/ml and sensitivity to ampicillin and tetracycline. Diagnosis: pregnancy and UTI.

6.A 22 month old boy has recent fatigue, and pale. Hb: 8.5 occult blood: positive. Admit, upper endoscopy: normal, colonoscopy: normal, Meckel scan: normal. Transfuse blood. Case ends due to time is up.

This case has been repeated many times recently. No one can find the cause of bleeding. I did not do barium enema for intussusception. This may be the answer.

7. A 5 year old African American boy with sickle cell disease presented intermittent right upper quadrant pain, radiating to back. Ultrasound: cholelithiasis. Direct bilirubin is elevated. Meperidine partially relieve pain. Consult general surgery. NPO, blood type and cross match. Diagnosis: biliary colic.

8. A 65 year old female under treatment of pneumonia in hospital suddenly developed dyspnea and no fever. CXR: normal. ECG: normal. ABG: low PO₂. Give O₂. V/q scan: high probability of PE. Give heparin, The symptom improved. Diagnosis: pulmonary embolism

can not remember case 9

CCS1:

in ER: 15 year old girl with history of asthma. come with wheezing and headache.
yellowish stuff inside the nose

work up

O₂

pulse oxymetry

PERF

albuterol nebulizer

steroid inhaler

then, physical exam

amoxicillin

cbc

CT scan of head showed sinusitis

nurse said pt got better

last 5 min

asthma education program

meds compliance

safe sex

wear seat belt

educate parent

...

Diagnosis

acute asthma

sinusitis

CCS2:

A woman is lethargic at dormitory, roommate does not know what is going on.

In ER:

O2

IV access

narcan

thimin

50% dextro

finger stick

blood toxicology

urine toxicology

result: glucose 600

transfer to ICU

Saline iv

insuline iv

U/A

urine culture

BMP q2 hour

ABG

K q2 hour

acute check q2

cardiac monitor

cbc

blood culture

EKG

chest x-ray

diabetic diet

computer showing ABG result indicating DKA, case ended

in last 5 minutes

meds compliant

diabetic diet

annual eye exam

annual orthopedic exam (foot)

acute check 4 times a day

insulin po

limit alcohol

avoid smoking

safe sex

...

Diagnosis: DKA

CCS3:

pt in ward treated with pneumonia developed shortness of breath. he is on antibiotics
O2

pulse oximetry

v/q scan

iv access

iv heparin

physical exam showing lower extremity edema

EKG

cardiac enzyme

troponin

v/q scan showing low probability for PE

Next

lower extremity doppler ultrasound: result normal

Next

echocardiogram showed congestive heart failure

next

lasix

digoxin

enalapril

elevation of head

salt limit diet

bed rest with bathroom privilege

nurse said pt getting better

next

pulmonary angiogram

case ended

Last 5 min

....

diagnosis: 1. congestive heart failure

2. pulmonary embolism

CCS4:

a middle age woman comes with right upper quadrant pain

IV access

pulse oximetry

physical exam

cbc

abdominal ultrasound showed stones in gallbladder

transfer to ward

NPO

saline + dextro

LFT

direct bilirubin

indirect bilirubin

u/A

cbc showed high WBC count

lipase

amylase

TMP/SMZ IV

metronidazol IV

type and cross

pt

ptt

surgical consult

case ended

last 5 min

...

diagnosis

cholilithisis

CCS5:

a women said she was very tired recently. She like alchohol. She feel nervous

complete physical exam

cbc

peripheral blood smear

THS

free T4

BMP

U/A

but I sent pt to home and ask come in three days. I massed up here. I care about pt too much

cbc showed macrocytic anemia

I order folate level and B12, computer refused me

I prescribe folate and B12 treatment, computer refused me again. I am hopeless. Pt getting worse

Last 5 min

I order folate level, B12 level

I also order folate treatment and B12 treatment
educate pt...

Diagnosis

folate acid deficiency due to alcohol or B12 deficiency

CCS6:

Office: A 60 year woman came with headache and pain in the body

complete physical exam

cbc

ESR showed elevation

prednisone

BMP

U/A

alkaline phosphatase

pt

ptt

type and cross

surgical consult for biopsy of temporal arteritis

computer said not now

I send pt home

then, they agree to do biopsy showing temporal arteritis

case end

Consult pt...

Diagnosis: temporal arteritis. PMR

CCS7:

one year old boy with lethargic, fever

iv access

O2

pulse oximetry

physical exam

cbc showed increase WBC

BMP

U/A

blood culture

LP

stool culture

transfer to ward

IV ceftriaxone

IV vancomycin

acetaminophen

IV 1/2 saline

IV 5% dextro

bed rest with bathroom privileges

CBC qd

Blood QD

boy gets better

I disconnect IV antibiotic, and change into PO, but boy throw out. I put IV line again and

IV antibiotic again!

Case ended

last 5 min

parent education...

diagnosis: bacteremia

CCS8:

immigrant, cough with yellowish sputum

PPD

Sputum AFB: negative

Sputum PCR for TB

Sputum culture for TB

Send pt to ward and isolate pt immediately

Physical exam

cbc
chest x-ray
BMP
U/A
Sputum PCR showed positive for TB

next
INH
rifampin
ethambutol
pyrazinamide
vit b6

pt did not get better (I think not enough time)
case ended
last 5 min
consult ...
diagnosis: TB

CCS9:

a woman came with vaginal discharge

physical exam

wet mount showed trichomonas
KOH
U/A
chlamydia culture
gonorrhea culture

I gave metronidazole
send pt home

pt had no significant change

My mistake: did not treat partner
also I did not check U/A result, I think she also had UTI, should have given antibiotic
Last 5 min, a lot of consult
diagnosis: trichomonas. UTI

1. 6yr old lower abd pain office admitted and xray abd lower pneumonia,,start ceftria and d/c on zithroma
 2. 20yr er ovarian cyst called obgyn and surgey scheduled
 3. 20 yr with pid and uti in office look sick to me so admitted and cefta and doxy iv and improved d/c home on oral doxy
 4. 30 yr truck driver office uti on exam prostritis and outpt uti improved
 5. 45 yr office female joint pain sob mild chest pain did pe had pleural effusion finding on lung and admitted thoracocen done ana positive ekg was n start prednisone improved send home on motrin ,predni
 6. 55 yr women er with abd pain did xray air was there and call surgery and scheduled for surgery
 7. 25 yr old had mva yesterday left ama primary and second survey done was n and now with luq pain did usg says possible splenic so confirm with ct and call surgrey and scheduled for that
 8. 17 yr old office with new onset dm and uti s/s and did finger stick 356 and admitted for r/o dka and serum osmo and ketone negative ,abg hco3 was 20 and gave insulin,k,ns did changed to sc insulin at 250 start diet and pt had uti so ceftria called nutriti for diet and hco3 was n and bs was 190 pt improved case done
 9. 73 yr h/o chf in er did xray,mild chf gave lasix was on digoxin,potas sparing diuretics,abg was abn and admitted in ward did not improve did v/q was positive for pe gave heparin and did ptt ,cbc f/u and did echo had moderate lvh and moderate mr and pt improved start on ace and bbloker

1. colon cancer

2.ITP

3.1 child with anemia which I could not get the exact diagnosis.

4.cystitis

5.pulmonary embolism in a cancer patient.

6.sedative poisoning

7.pneumonia

8 obesity

9cholecystitis

UTI

ADENOCARCINOMA IN WOMEN IN FIFTIES

DOUDENAL ATRESIA

LEAD POISINING IN 18 MO OLD

PERICARDITIS

PERICARDIAL EFFUSION

DUB

UNCONSCIOUS MAN IN 40 WITH R/R 8

G6PD

CIN III

Iron def anaemia

General check up of a boy with HTN.& obesity.

pulm embolism in colon ca pt

Cystitis,

Cholelithiasis

pneumonia

Diverticulitis

1. erosive gastritis

2. cholelithiasis in a sickle cell pt

3. pid

4. uti in a pregnant

5. military recruit

6. idiopathic thrombocytopenic purpura

7. right lower lobe pneumonia

8. pulmonary emboli

9. iron deficiency anaemia in 18 month old baby

A 30 year old female patient with a cold and infraorbital headache --maxillary sinusitis.

2. A Latino 30 yr old pharmacist with low grade fever and PPD test positive -- treatment of tuberculosis.

3. A Latino male who is s/p colon carc resection and admitted to hosp. for treatment of pneumonia developed chest pain - pul.edema/chf.

4. A Latino alcoholic female who is pale and tired; cbc shows hyperseg. neutrophils and increased MCV--follic acid deficiency anemia.

5. A Latino 12 month old child with high fever (40 C) --blood culture showed gram positive cocci in pairs(work up of sepsis)

6. A 25 year old female with H/o DM Type I came to er with n/v loss of appetite ---DKA with urinary tract infection (as UA showed positive nitrites and leukocytes)

7. A young female with burning urination and foul smelling vag discharge--Trich vaginitis.

8. A 60 year old female with headaches and stiffness of joints----Polymyalgia rheumatica.

1- polycystic kidney disease: 50 y.o.w.m with PMH of HTN presented with mental problem (I dont remember). I did UA, sma7 and then Echo which was diagnostic. hemodialysis..

2- angioderma: shellfish with edema in face and lips and SOB. epineph and o2...discharge.

3- pneumonia (60 y.o.w with right upper abdominal pain had URI three days ago): CXR and erythromycin only!!!!

4-acute diverticulitis (50 y.o.AA.w. with left lower abdominal pain, no Occult blood), exam abdomen and rectum only!, showed mass, KUB: dilated loops. metro and cefotaxim and sendf home on diet.

5- chf with sob, R/O MI and supportive care and add HCTZ for his regimen which included aspirin and ACEI.

6-dmII (tricky). prostate problem in a 60 y.o.m presented with thirst and improved urinary problems.. glucose only...350.. workup diet and other junk stuff and send home and F/U...The only thing happen in this case that he was still thirsty which i called him in and hydrate him..and then all massges were ok.

7- sickle cell anemia with chest pain. supportive ICU and hydroxyurea.

8- HTN, stage I: AA boy wants to be involved in football team HTN repeat and repeat....then diet, smoke alcohol, drugs.... improves over 3 months...and happy!!!!

9- pid classic easy.

1)ectopic pregnancy

2)perforated PUD

3)Anginal pain

4)Fe deficiency anaemia in pregnancy

5)Vaginal discharge,culture negative

6)known NIDDM with c/o lethargy,leg pain?

7)PID

8)ITP

9)postmenopausal female c/o of hot flashes

10)Tension pneumothorax

H. pylori assoc.'d Duod. Ulcer

2) Idiopathic Thrombocytopenia

3) Pulm. Embolus

4) Pneumonia due to Strep. pneum.

5) Pregnancy w/ UTI

6) Sickle Dz w/ Cholelithiasis

7) EtOH Tox. w/ Intubation ?

8) Iron Def. in 15mos Infant

9) Hypertriglyceridemia in Teenager

1.narcotic poisoning-friend bought the pt in unconscious state,the day before she took painkillers from friend.pt presented with resp.depression,miosis.

2.pleural effusion-when i did ANA,turned out to be positive(SLE)

3.acute cystitis in a teenager.she presented with dysuria,and polyuria,polydypsia,urineketones+,high BSL--dka

4.5yold with lowerlobe pneumonia-came with abdominal pain and fever,poor feeding.

5.acute prostatitis in 25yrs pt.urine analysis had no bacteria.

6.PID in a teenager

7.CHF+DVT+pul embolism-long travel history with acute shortness of breath,nocturnal dysnea,lower leg edema.v/q was positive,echo showed lvf.

8.diverticulitis(fobt -ve)presented with diffuse abdominal pain,more tender in LLQ,abd xray positive for air under diaphragm,ct was positive for sigmoid diverticulitis.

9.splenic rupture-pt.was beaten and mugged,he was in the ER,then dint wanted to take treatment and so left.but he came now with body aches and shortness of breath.US was positive for splenic rupture and DPL was also positive,surgeon agreed to treat.

CCS

Torsion of the ovary in a 23 yo female

Viral Pneumonia in a 6 yo African American boy

Nephrolithiasis in a truck driver – passing stone with UTI on UA

Sigmoid diverticulitis with pericolic abscess and free air in the peritoneal cavity in a 46 yo obese, sedentary, caucasian women

New-onset DM in a 17 yo girl with UTI

Community acquired pneumonia in a 45 yo women

Splenic hematoma in a middle-age Asian American man

Pulmonary Embolism in a man who was in a long flight from Australia – pt with hx of CHF and HTN

PID in an 18 yo pt that didn't meet criteria for admission (tx with one time dose of ceftriaxone and azithromycin and f/u in 24hrs)

Tricuspid Endocarditis

Acute chest syndrome. Sickle Cell

Chron disease

Pneumonia and Lung cancer

ACHF

Pericardial tamponade after MVA

Vaginosis

ACute renal failure due to rhabdomyolysis

DUB in girl with hemophilia